Maternal and Child Health Services
Title V Block Grant

State Narrative for Michigan

Application for 2015
Annual Report for 2013

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

A copy of the Assurances (non-construction programs) and Certifications may be obtained by contacting the Title V Director's Office at 517-335-8928.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

The draft application was posted on the Department's website. Public input was invited through direct notification via email to advisory groups, local health departments, advocacy groups and other state programs, and through the DCH Facebook and Twitter pages.

In addition to soliciting public comment on the draft application itself, we work, on an ongoing basis, without outside entities representing advocates, advisory bodies, providers, and consumers throughout the year to receive input on the programs, policies and plans included in the Title V application. To implement our Infant Mortality Reduction Plan, we work with a steering team consisting of providers from hospitals, local health departments, and research institutions, and representatives from Primary Care Association, Michigan Health and Hospital Association, professional associations, community organizations, Inter-Tribal Council of Michigan, advocacy organizations, Michigan Association of Local Public Health, Michigan Association of Health Plans and the W.K. Kellogg Foundation.

The Children's Special Health Care Services program works routinely with parent consultants through the Family Center to provide information and support to families and to receive input on program operations. A Youth Consultant position was created to participate in CSHCS Division strategic planning and advisory meetings. The Youth Consultant provides review and offers guidance to make division materials and outreach activities more youth friendly. The youth consultant is being connected with AMCHP and other national and local resources to optimize the value of work produced.

A partnership with MDCH, the Inter-Tribal Council of Michigan, Great Lakes Intertribal Epidemiology Center, and Michigan State University formed to design a survey to include only mothers of Native American infants. The project interviews women to find out what can be done to create better opportunities for good health among Native Americans in Michigan. Mothers of all Native American infants born in 2012 received an invitation to participate in the survey beginning in summer 2012 and continuing through summer 2013. A contractual agreement was established with the Inter-tribal Council of Michigan to collaborate with the PRIME Steering Team and Intervention Workgroup to inform the project about the culture and history of Native Americans that influence health behaviors and contribute to disparities in infant mortality.

Other programs work with outside entities either through advisory bodies (e.g., Family Planning) or on a project basis to receive input on aspects of the program (e.g., redesign of the Maternal and Infant Health Program, development of a regional perinatal system of care).

The Parent Leadership in State Government project identifies, trains and supports parent leaders from among families who utilize specialized public services provided through DCH, Education, Human Services and/or their local counterparts, with a focus on providing consumer voice and input on local, state and federal program planning and policy development that impacts children and families.

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

There are no changes to State priorities for maternal and child health for the report or planning period.

In August of 2012, the Michigan Infant Mortality Reduction Plan was released identifying eight priority recommendations: 1) implement a regional perinatal system; 2) promote adoption of policies to reduce medically unnecessary deliveries before 39 weeks gestation; 3) promote adoption of progesterone protocol for high risk women; 4) promote safer infant sleeping practices to prevent suffocation; 5) expand home visiting programs to support vulnerable women and infants; 6) support better health status of women and girls; 7) reduce unintended pregnancies; 8) weave the social determinants of health into all targeted strategies to promote reduction of racial and ethnic disparities in infant mortality. In 2013, we continued to work with our partners from academia, advocacy, health care providers, professional organizations, local health departments and other state departments to implement the strategies outlined in the Plan. Some of the accomplishments during the past year are:
Updated quality assurance standards to support statewide improvements in care systems.
Collaboration with Certificate of Need to develop new quality improvement monitoring standards for hospitals' special care nursery beds
Eighty-four Medicaid birthing hospitals signed agreements to implement one or more policies to eliminate elective, non-medically necessary deliveries before full-term pregnancy.
Created provider and community awareness of the importance of all babies having their full time to grow and develop before birth.
Created two media presentations for high risk community markets to raise awareness of safe sleep.
Provided infant safe sleep education and resources to community partners serving parents and caregivers before, during and after pregnancy.
Collaborated with the Department of Human Services to develop legislation to raise parental awareness of safe sleep by requiring hospitals to provide safe sleep education after birth and prior to discharge.
Created four new Nurse Family Partnerships in urban areas where African American infant deaths are among the highest in the state.
Published two articles on the success of the Maternal Infant Health Program documenting improvements in prenatal care, infant care, and reduction in low birth weight and preterm births.
Developed an Oral Health Plan for preconception, prenatal and postpartum women to determine impact on birth outcomes.
Offered tobacco quit line and training to providers on evidence-based quit smoking interventions to reduce prenatal smoking.
Served 7892 youth and 2093 parents via teen pregnancy prevention programming in 21 sites throughout the state.
Completed the first Native American Pregnancy Risk Assessment Survey to understand the needs of the high risk population in the context of their ethnic and cultural environments and improve services to meet their needs.
Released the first Michigan Health Equity status report to focus on maternal and child health and influential social factors that affect reductions in infant mortality.

In the fourth year of our grant from the Kellogg Foundation for the PRIME (Practices to Reduce Infant Mortality through Equity) project, the focus was on completing training of staff on health equity issues. The Women, Infants and Children (WIC) Division participated in Health Equity

Learning Labs. The Goals of the Health Equity Learning Labs are: 1) To foster institutional change to develop policies and procedures that always promote, and NEVER inhibit health equity; and 2)To incorporate equity thinking, perspectives and action into daily work assignments and responsibilities. Additionally, the Children's Special Health Care Services (CSHCS) Division completed an Organizational Assessment and participated in a 2.5 day Health Equity and Social Justice workshop. The CSHCS Division will participate in the Health Equity Learning Labs in 2014.

The PRIME website (http://prime.mihealth.org/) was launched in January 2013. The website includes relevant data on infant mortality and definitions and videos that describe health equity, social determinants of health and racism. The Local Learning Collaborative (health departments, Healthy Start projects, and other community organizations) discuss their lessons learned and best practices in local health equity work. Areas within MDCH share their health equity work and initiatives. The website includes a variety of articles, reports and films that discuss infant mortality, health equity and racism.

The PRIME Local Learning Collaborative (LLC) continued to share their opportunities and challenges in addressing racism and equity within their local agencies. In August 2013, the group supported merging the LLC and the Partnership to Eliminate Disparities in Infant Mortality (PEDIM) Action Learning Collaborative. PEDIM ended in February 2013. Most of the members of PEDIM (Healthy Start Projects) were already a part of the LLC. The three strategies of PEDIM align with the work of the LLC and were to: 1) Promote participation in workshops and trainings that address racism, health equity, and social justice; 2) Compile toolkits to provide tools and resources to un-do racism; and 3) Improve both the quality and the quantity of data collection related to race and ethnicity within the health care system.

This is the last year of the Kellogg grant for the PRIME project. A no-cost extension was approved by the Foundation through September 2014 to complete the training curriculum and resource materials. A new grant request has been submitted to Kellogg to implement the curriculum in other areas of the Department.

The Department continued with a second year of participation with the Vermont Oxford Network (VON) to improve the identification and treatment of infants born with Neonatal Abstinence Syndrome. Data is being collected from eighteen hospitals with Neonatal Intensive Care Units and six Level II hospitals.

In September of 2013, The Governor signed into law Public Act 107 creating the Healthy Michigan Plan. The Health Michigan Plan expands Medicaid coverage for individuals who: are age 19-64 years; have income at or below 133% of FPL under the Modified Adjusted Gross Income methodology; do not qualify or are not enrolled in Medicare; do not qualify or are not enrolled in other Medicaid programs; are not pregnant at the time of application; and are residents of the State. Because the State Legislature did not give the Act immediate effect, the program did not start until April 1, 2014. Nearly 200,000 people have signed up for this coverage in the first month that applications have been accepted. It is expected that up to 320,000 will sign up in the first year, eventually rising to 470,000.

In addition to expanding insurance coverage options for low-income adults, more than 272,000 people in Michigan have signed up for insurance under the federal exchange as of May 1, 2014. Of that number, approximately one-third were younger than 35. At the same time, Michigan's Plan First Family Planning program (Medicaid waiver) is being phased out by the Department. This program covered family planning services for women beyond the postpartum period. The assumption is that coverage can be obtained through either Medicaid or through the health insurance exchanges.

III. State Overview

A. Overview

The Title V program in Michigan operates within the larger context of public health services as articulated in the Department of Community Health's mission statement: "...to promote access to the broadest possible range of quality services and supports; take steps to prevent disease, promote wellness and improve quality of life; and strive for the delivery of those services and supports in a fiscally prudent manner." To accomplish this mission, the department employs a variety of resources including federal, state and local funding to provide, arrange or assure access to a broad range of health and other social services. In accordance with the Public Health Code, local health departments are our main partner in fulfilling our Public Health Mission. Services are arranged and delivered at the community level through a variety of public and private agencies, including local health departments, hospitals, clinics, private practices, schools, Planned Parenthood organizations, migrant health centers, and primary care centers. Cooperative efforts to achieve specific initiatives are arranged with the private sector, such as managed care plans, universities, Delta Dental of Michigan, Blue Cross/Blue Shield of Michigan, Michigan State Medical Society, and Michigan Association of Broadcasters. Within the Department of Community Health, Title V programs and planning and policy activities are coordinated with the Medicaid program, MIChild (state CHIP), mental health and substance abuse services, chronic disease programs, communicable disease programs, and injury prevention programs. The Department also works cooperatively with other State departments on issues of mutual responsibility.

The Title V program is operated by the Bureau of Family, Maternal and Child Health. The Title V Director is also the Director of the Bureau. The Bureau includes the Division of Family and Community Health, Children's Special Health Care Services Division, and the WIC Division. The Division of Family and Community Health manages all of the MCH programs besides CSHCN. The Title V Director reports to the Deputy Director for Public Health who reports to the Director of the Department of Community Health (see attached organization chart). The Department of Community Health is composed of five administrations which include Medicaid (Medical Services Administration) and Mental Health and Substance Abuse.

The public health functions of assessment and assurance are shared between the Department of Community Health and local health departments (LHD). Under the Public Health Code, all counties are required to provide for a local health department and are charged with: prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable populations; development of health care facilities and services delivery systems; and regulation of health care facilities and services delivery systems to the extent provided by law. There are 30 single county health departments, 14 district health departments covering multiple counties, and one city health department. See Section III.E below for further discussion of the role of local health departments.
/2013/ Due to a critical financial situation, the Mayor of the City of Detroit has proposed elimination of the city's health department. A proposal to turn over the responsibilities of the city health department to a public nonprofit agency, the Institute for Population Health, effective October 1 2012, has been advanced and is being considered by the City Council. Under the Public Health Code, Detroit is not required to operate a health department. Another option is for Wayne County to take over responsibility for public health activities within Detroit.//2013//
/2014/The Institute for Population Health was created as a public non-profit agency to assume the local public health services for the City of Detroit. The Institute began providing services in October 2012.//2014//
/2015/Due to legal concerns, some core services will be pulled back into the City of Detroit health department. The plan is to directly manage essential local public health services (hearing and vision screening, immunizations, communicable diseases, STD/HIV) and to contract for other services including WIC and Children's Special Health Care Services.//2015//

The Title V program also works across state departments on initiatives that affect our mutual customers. The Title V Director serves on the Board of the Children's Trust Fund that serves as a voice for Michigan's children and families and promotes their health, safety, and welfare by funding effective local programs and services that prevent child abuse and neglect. Another inter-agency initiative is the Great Start Initiative which supports a comprehensive early childhood system of care (ECCS). This initiative began with a State Early Childhood Comprehensive Systems grant from HRSA in 2003 and now serves children and families statewide through local collaborative teams.

According to the U.S. Census Bureau, Michigan's population as of July 1, 2009 was 9,969,727. The state population has remained fairly steady over the past decade, ranging from 9,938,444, according to the April 1, 2000 Census, to a high of 10,090,554 in 2005. Births in Michigan have declined since 2000 by 14.3%. Michigan's rate of net migration to other states was 1.1 % in 2008. From 2000 to 2006, Michigan's out-migration rate was very close to the average for all states, but increased in 2007 and 2008. More than 80% of the state's population resides in the southern half of the Lower Peninsula; almost half of the population resides in southeastern Michigan. Approximately 3.1% of the state's population resides in the Upper Peninsula. About 19% of the state's population resides in rural areas.
/2012/According to the 2010 US Census Report, Michigan was the only state to lose population between 2000 and 2010, experiencing a drop of 0.7%. The City of Detroit was especially impacted, experiencing a drop of approximately 25% in population during the decade. The white, black and Native Hawaiian/Pacific Islander populations declined, while the Native American, Asian, and Hispanic populations increased. The Asian population increased by 34.9% and the Hispanic population increased by 34.7%.//2012//

According to the US Census Bureau, in 2009 Michigan's population was 81.1% white, 14.2% African American, 2.4% Asian/Pacific Islander, 0.6% Native American and 1.6% two or more races. 4.2% of the population was of Hispanic ancestry. The demographic profile of the state indicates significant increases over the last two decades in the percentage of residents that are Asian/Pacific Islander and Hispanic. From 1990 to 2009, the percentage of residents that were Asian/Pacific Islander increased 100%, and the percentage that were Hispanic ancestry increased 90.9%. Over the same time period, the proportion of the population that was white decreased by 3.6% and the proportion that was African American increased by 1.4%. The proportion of the population that was Native American remained the same.

In 2008, 23.9% of the population was under 18 years of age; 36.0% were 18-44 years; 27.1% were 45-64 years; and 13.0% were 65 years and older. From 1999 to 2008, the population under 18 years of age declined by 7.6%, and the population 45 years and older increased by 18.1%. Among the population under 18 years of age, 77.6% were white, 18.6% were Black, 0.9% were Native American, and 2.9% were Asian/Pacific Islander. 6.4% of the population under 18 years of age were Hispanic.

Among people 5 years of age or older, 9% spoke a language other than English at home. 34% of those spoke Spanish and 66% spoke some other language.

According to the Current Population Survey, 2008, 13.0% of the total population was below the federal poverty level, and 19.1% of children under 18 were below poverty level. In 2006-2008, 10.0% of all families and 31.0% of families with a female householder and no husband present had incomes below poverty. During the same three-year period, the median income of households in Michigan was $49,694. For the first half of fiscal year 2009, more than 20% of the population was receiving some form of public assistance benefits. The WIC program serves more than 50% of infants in Michigan.
/2012/The economic difficulties in Michigan continued to place heavy demand on public assistance programs. During FY2010, on average approximately 24% of the state's population received some form of public assistance, a 14% increase over 2009.//2012//

/2013/ Public assistance programs continued to grow in 2011. The monthly average number of recipients grew by 6.4%, representing 26% of the state's total population.//2013//
/2014/The monthly average number of recipients of public assistance declined by approximately 3% from 2011 to 2012, reflecting some improvement in the state's economy. The number of children in families receiving public assistance also declined by 4.6%. According to the American Community Survey, 2011, 17.5% of the state's population was below poverty, while 24.8% of children under 18 years were below poverty.//2014//
/2015/The percent of Michigan residents in poverty increased from 10.9% in 2007 to 17.5% in 2011, then decreased to 17.4% in 2012. The percent of children under age 18 in poverty continued to increase from 2007 to 2012 (15.9% in 2007, 24.9% in 2012).
The total number of public assistance recipients in Michigan more than doubled from 2007 to 2011. Since 2011, the number of recipients has declined by 4.5%, reflecting the gradual improvement in the state economy. The number of persons receiving food assistance increased by 60.1% between 2007 and 2011, and has decreased by 8.1% from 2011 to 2013. Medicaid recipients increased by 78.3% between 2007 and 2011, and decreased by .9% from 2011 to 2013.//2015//

Michigan's economy has suffered severely over the past two years. According to the U.S. Bureau of Labor Statistics, employment in Michigan in 2008 declined by 3.2%. Payroll jobs in transportation equipment manufacturing decreased by 36.5% from December 2007 through October 2009; durable goods manufacturing declined by 26.4%; and construction by 24.0%. The 2009 average annual unemployment rate was 14.0% compared to the U.S. rate of 9.2%. The unemployment rate reached a peak of 15.3% in September 2009. Job losses have slowed in the state as the economy generally improved and auto industry production resumed, albeit at lower levels. As of May 2010, the Michigan unemployment rate was 13.6% compared to the U.S. rate of 9.7%. Recovery will be slow as Michigan's economy evolves from heavy dependence on the auto industry to a service-based economy.
/2012/Michigan continues with a slow economic recovery. For May 2011, the unemployment rate in Michigan was 10.3% compared to a US rate of 9.1%.//2012//
/2013/ The jobless rate in Michigan cotinued to decline in Michigan, falling to 8.3% in April 2012.//2013//

Due to the manufacturing history of Michigan and the strong presence of unions, the state has enjoyed a relatively high proportion of the population that was insured. However, with the decline of the auto industry and the general economic downturn, the number of uninsured residents is increasing. Overall, the uninsured population in Michigan increased from 1.04 million in 2006 to 1.15 million in 2007. Although Michigan had one of the lowest uninsured rates for children, a 2009 report by the Center for Healthcare Research and Transformation indicated that the percent of uninsured children (0-18 years of age) increased from 4.7% in 2006 to 6.2% in 2007, and the percent of uninsured young children (0-5 years) increased from 4.6% to 7.8% during the same period. African Americans and Hispanics were disproportionately represented in the uninsured population.
/2012/During FY 2010, an average of 1,862,261 persons received Medicaid benefits, an increase of 9% over 2009. According to Kaiser Family Foundation State Health Facts, coverage of children 0-18 by employer-sponsored insurance declined by 2.1% between 2007 and 2009, by individual insurance declined by 0.5%, and by Medicaid increased by 3.4%. Among all persons ages 0-64, coverage by employer-sponsored insurance decreased by 4.5% between 2007 and 2009, by individual insurance increased by 0.1%, and by Medicaid increased 2.3%.//2012//
/2013/ The average monthly number of Medicaid recipients increased by 3.8% from 2010 to 2011. The average monthly number of children under age 21 receiving Medicaid benefits increased by 10.3%. According to the Kaiser Family Foundation State Health Facts, employer-sponsored health insurance coverage declined by 3.6% for persons 0-64 years of age, and by 3.8% for children under age 21. Individual insurance coverage increased by 0.5% for persons 0-64, while individual coverage for children under age 21 decreased by 0.4%.//2013//
/2014/The average monthly number of Medicaid recipients declined from 2011 to 2012 by 0.7%. Medicaid recipients under 18 years of age increased slightly from 2011 to 2012 by less than 1%.

The uninsured rate for children was 4.1% in 2011, unchanged from the previous year according to the American Community Survey for 2011.//2014//
/2015/In 2013, the total number of Medicaid recipients declined slightly from 2012, while the number of pregnant women with children under 19 receiving Medicaid benefits increased by 2.5%. In September of 2013, The Governor signed into law Public Act 107 creating the Healthy Michigan Plan. The Health Michigan Plan expands Medicaid coverage for individuals who: are age 19-64 years; have income at or below 133% of FPL under the Modified Adjusted Gross Income methodology; do not qualify or are not enrolled in Medicare; do not qualify or are not enrolled in other Medicaid programs; are not pregnant at the time of application; and are residents of the State. Because the State Legislature did not give the Act immediate effect, the program did not start until April 1, 2014. Nearly 200,000 people have signed up for this coverage in the first month that applications have been accepted. It is expected that up to 320,000 will sign up in the first year, eventually rising to 470,000.//2015//

Distribution of health care resources is a significant factor in accessing health care. According to Michigan Strategic Opportunities for Rural Health Improvement: A State Rural Health Plan, 57 of the 83 counties in Michigan are defined as rural, containing 19% of the state's population. Rural Michigan has 165 physicians per 100,000 population, compared to 272.9 physicians per 100,000 population for the state as a whole. Two-thirds of the hospitals in Michigan are in metropolitan counties, and 40% are located in southeastern Michigan. Most of the specialty care for children is located in the southern portion of the lower peninsula of the state.
/2012/In 2010, two more hospitals in the northern portion of the Lower Peninsula closed their delivery units, bringing the total of contiguous counties without OB services to 16. This is a largely rural area. The issues cited were lack of service profitability, inability to recruit and retain qualified physicians, low Medicaid reimbursement levels and malpractice costs. Additionally, pediatricians have been leaving the area. A group of representatives from area hospitals, local and state health departments and provider organizations have been meeting to research solutions to this problem.//2012//

The leading causes of death for infants under age 1 in 2008 were certain conditions originating in the perinatal period, congenital malformations, accidents, SIDS and homicide. Black infants died at 2.7 times the rate of white infants; Hispanic infants at 1.6 times the rate for whites; and American Indian infants at 1.5 times the white rate. The five-year (2004-2008) average low birth weight rate (8.4) increased over the preceding five-year period (8.0). Black infants were more than twice as likely to have low birth weight as white infants. The pre-term birth rate was relatively unchanged from 2003 to 2008.
/2013/ The overall Infant mortality rate declined to 7.1 per 1,000 live births in 2010. Although the percentage of preterm births also declined, the low birth weight rate was unchanged. Disparities persisted between black (14.1) and white (5.5) infant mortality rates and between American Indian (10.5) and white infant mortality rates.//2013//
/2014/ The leading causes of death for infants under age 1 in 2010 were low birth weight, congenital anomalies, accidents, SIDS, maternal complications, and homicide.

Michigan's Infant Mortality Rate has been declining over the last decade with the exception of 2007, yet remains higher than the national rate. The infant mortality rate in Michigan declined to 7.1 per 1000 in 2010 from 7.4 per 1000 in 2008. According to provisional data, the rate of infant deaths was 6.5 per 1000 in 2011. The infant mortality rate among Black and American Indian infants is more than twice the state rate and almost 3 times higher than White infants. //2014//
/2015/Michigan's final infant mortality rate for 2012 was 6.9 overall, an increase over 2011 but still lower than in the previous ten years. The provisional rate for 2013 is 6.6. The white IM rate increased from 4.9 in 2011 to 5.5 in 2012, and the black IM rate decreased from 13.7 to 13.5. IM rates for Native Americans and Hispanics also increased from 2011 to 2012 -- from 9.3 to 14.1 for Native Americans and from 5.6 to 9.7 for Hispanics.//2015//

The overall infant mortality rate in Michigan in 2008 was 7.4. Of the 83 counties in Michigan,

eleven counties had a higher infant mortality rate than the state rate -- Berrien (7.8), Calhoun (7.9), Genesee (8.1), Grand Traverse (8.2), Kent (7.5), Lenawee (9.6), Mecosta (20.5), Saginaw (10.2), Saint Joseph (11.0), VanBuren (10.2), and Wayne (10.7)

Among cities with populations greater than 40,000 and more than 200 average number of births, the following cities had the highest average rate of infant mortality in the state in 2008:

Detroit -	14.9	
Pontiac -		13.3
Saginaw -		12.7
Flint -	11.8	
Southfield -	11.5	
Wyoming -	10.1	
Taylor -	9.4	
Grand Rapids -	8.7	
Lansing -		8.5
Battle Creek -	8.0	

Wayne County (including Detroit), Genesee County (including Flint), and Saginaw County had the highest rates of low birth weight.

The Department's focus for addressing infant mortality over the next several years will be on improving the health of mothers, pre- and post-pregnancy. Programs to address chronic conditions, such as diabetes and obesity, will be pursued. Of the live births in 2008, 15.9% of mothers were exposed to second-hand smoke at home, 27.5% of mothers with singleton births had a body mass index above 29.0, 0.8% had pre-pregnancy diabetes, 3.8% had gestational diabetes, 1.2% had pre-pregnancy hypertension, and 4.4% had gestational hypertension. American Indian mothers had the highest rate of exposure to second-hand smoke. Asian/Pacific Islander mothers had the lowest rate of BMI greater than 29.0, but had the highest rate of gestational diabetes.
/2013/ A statewide summit on infant mortality was held in October 2011. From the summit, seven strategies were recommended to reduce the overall infant mortality rate in Michigan and the disparity in infant mortality rates between racial and ethnic groups: 1) implement a statewide regional perinatal system; 2) promote adoption of "Hard Stop" policies to reduce medically unnecessary deliveries before 39 weeks gestation; 3) promote adoption of progesterone protocol for high risk women; 4) promote safer infant sleeping practices to prevent suffocation; 5) expand home visiting programs to support vulnerable women and infants; 6) support better health status of women and girls; and 7) reduce unintended pregnancies.
/2015/In 2013, we continued to work with our partners from academia, advocacy, health care providers, professional organizations, local health departments and other state departments to implement the strategies outlined in the Plan. Some of the accomplishments during the past year are:
Updated quality assurance standards to support statewide improvements in care systems.
Collaboration with Certificate of Need to develop new quality improvement monitoring standards for hospitals' special care nursery beds
Eighty-four Medicaid birthing hospitals signed agreements to implement one or more policies to eliminate elective, non-medically necessary deliveries before full-term pregnancy.
Created provider and community awareness of the importance of all babies having their full time to grow and develop before birth.
Created two media presentations for high risk community markets to raise awareness of safe sleep.
Provided infant safe sleep education and resources to community partners serving parents and caregivers before, during and after pregnancy.
Collaborated with the Department of Human Services to develop legislation to raise parental awareness of safe sleep by requiring hospitals to provide safe sleep education after birth and prior to discharge.

Created four new Nurse Family Partnerships in urban areas where African American infant deaths are among the highest in the state.
Published two articles on the success of the Maternal Infant Health Program documenting improvements in prenatal care, infant care, and reduction in low birth weight and preterm births.
Developed an Oral Health Plan for preconception, prenatal and postpartum women to determine impact on birth outcomes.
Offered tobacco quit line and training to providers on evidence-based quit smoking interventions to reduce prenatal smoking.
Served 7892 youth and 2093 parents via teen pregnancy prevention programming in 21 sites throughout the state.
Completed the first Native American Pregnancy Risk Assessment Survey to understand the needs of the high risk population in the context of their ethnic and cultural environments and improve services to meet their needs.
Released the first Michigan Health Equity status report to focus on maternal and child health and influential social factors that affect reductions in infant mortality.//2015//

In September 2011 a statewide summit on obesity was held to engage stakeholders from across the state in the development of actions to reduce the obesity rates among the population overall and children. From the summit recommendations, the Department developed the "4 X 4 Plan" with the following strategies and goals:

Maintain a healthy diet	Body Mass Index
Engage in regular exercise	Blood Pressure
Get an annual physical examination	Cholesterol level
Avoid all tobacco use and exposure	Blood sugar/glucose level

A.Develop multimedia public awareness campaign to encourage every resident to adopt health as a personal core value through promotion of the 4 X 4 Plan
B.Deploy 46 community coalitions throughout Michigan to support implementation of the 4 X 4 Plan
C.Engage partners throughout Michigan to help coalitions implement the 4 X 4 Plan: employers, trade and other professional organizations; education system; and departments of state government.
D.Within MDCH, create the infrastructure to support 4 X 4 Plan implementation energizing the local coalitions and partners.//2013//

According to the County Health Rankings for Michigan , the following counties had the best rankings in both Health Outcomes and Health Factors: Livingston (central Lower Peninsula), Ottawa (southwestern Lower Peninsula), Leelenau (northern Lower Peninsula), Clinton (central Lower Peninsula), Washtenaw (southeastern Lower Peninsula), Grand Traverse (northern Lower Peninsula) and Marquette (Upper Peninsula). The only major city (population > 40,000) in this area is Ann Arbor (Washtenaw County).

The counties with the worst rankings in both categories were: Saginaw (central Lower Peninsula), Calhoun (southern Lower Peninsula), Gladwin (central Lower Peninsula), Genesee (central Lower Peninsula), Lake (northern Lower Peninsula), Wayne (southeastern Lower Peninsula) and Clare (northern Lower Peninsula).
/2015/According to County Health Rankings & Roadmaps 2014 Rankings for Michigan, the counties with the lowest ranking for health outcomes were: Wayne (including Detroit), Genesee, Arenac, Alcona, Calhoun, Oscoda, Gladwin, Kalkaska, Alpena and Saginaw. The counties with the lowest rankings for health factors were: Wayne, Lake, Montmorency, Baraga, Gladwin, Roscommon, Clare, Arenac, Oceana, and Kalkaska. Three of these counties contain significant urban areas (Wayne, Genesee and Calhoun); the rest are predominantly rural.//2015//

The leading causes of death among children ages 1-19 in 2008 were accidents, assault

(homicide), cancer, suicide and congenital malformations. The leading causes of hospitalizations for children were females with deliveries, injury and poisoning, asthma, pneumonia and appendicitis. Births to teens aged 15 to 17 years declined from 2004 (18.7%) to 2007 (14.0%), but then increased significantly in 2008 (18.2%).

B. Agency Capacity

The Division of Family and Community Health (DFCH) is responsible for assessing need, recommending policy, developing and promoting best practices and service models, and advocating for the development of capacity within communities to provide quality, accessible, culturally competent services. We focus on improving the health, well-being, functioning and/or quality of life for infants, children, adolescents, women of childbearing age, and their families. Maternal and child health programs, policy development and activities focus on assessment of health status, identification of priority health issues, and development and support of health care programs and systems to address these health issues in the context of health care reform and with culturally competent approaches to service delivery.

The life-course framework is the structural model for the organization of the division and its strategic plans to address the needs of the population served to meet the department's mission "to protect, preserve and promote health with special attention to the needs of the vulunerable and underserved." The division's organizational unit structures are based on life stages: reproductive/preconception/interconception, maternal/interconception, infant, child, adolescent and family (oral health -- crossing all life stages). The division continuously supports linkage to the adjacent life phase of which each individual grows and develops with the impact of the complex interplay of the social determinants of health.

The health of a woman prior to pregnancy has a significant impact on pregnancy outcome and the early health of the infant sometimes more than interventions during pregnancy. Priority is being placed on increasing health promotion and prevention activities including strategies to increase access to effective social-emotional, medical and dental health for women. Mental health service availablity and improvement of social determinants of health are addressed as a component of improving the overall health of women. Interconception care is a subset of preconception care, comprised of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management, emphasizing those factors which must be acted on before conception or early in pregnancy to have maximum impact. It is more than a single visit and less than all well-woman care.
/2012/ The department also promotes and supports the concept and model of family centered medical home for all pregnant women, infants and children. //2012//

For all the life course stages we connect to and work with other organizational units of the Department and community partners who may be technical experts and/or are responsible for oversight of assessment, strategic planning and implementation of care systems and policies for other health care and/or social determinates of health (mental health; substance abuse; child development; early, middle and adolescent education; chronic disease development; healthy environments, etc.). Each unit within the DFCH addresses these factors, concentrating on the portion of the life course they are responsible for, but also by building on, coordinating and complementing the other life course stage immediately adjacent or relevant.

To support relevant and culturally sensitive planning efforts, the division uses advisory groups; develops and holds work groups of diverse representatives; conducts focus groups; and supports, employs or contracts for ongoing parent or population representatives to have ongoing or episodic input into the planning and sometimes the monitoring process of our efforts. In

addition, all managers have as a performance objective to value and secure a diverse work environment that ensures compliance with equal opportunity in hiring, training and assignments to assure diversity in the views brought to bear in our operations.

During the last year and a half there have been conducted division-wide cultural sensitivity trainings and the division's director and section managers have participated in cultural sensitivity trainings. One of our intents is to improve all staff's awareness for the need to gather and monitor appropriate data on the diversity of the state's population and the disparity in the health statistics in each life course stage. There are multiple representatives working on the Department's Health Disparities Work group. Some of this group's charges are to increase awareness of health disparity, and collect and disseminate relevant data to distribute information focusing on eliminating disparities and ensuring policies, programs, and implementing strategies that are culturally and linguistically tailored to reduce morbidity and mortality.

The Reproductive Health Unit is responsible for preconception and interconception health planning and promotion. The primary service area is the delivery of quality, equitable, scientifically safe contraception and reproductive health care services via the implementation of the Federal Title X Family Planning program. As the long-term single, state-wide grantee for Title X Federal funds, the Family Planning Program makes available general reproductive health assessment, comprehensive contraceptive services, related health education and counseling, and referrals as needed to Michigan residents. Services are available to anyone, but the primary target population is low-income women and men. Following Title X regulations services are delivered through a statewide network of local health departments, Planned Parenthood affiliates, hospitals and private non-profit agencies.

Michigan Department of Community Health (MDCH) received approval of its Mediciad Section 1115 Family Planning Waiver July 1, 2006, expanding Medicaid supported family planning services to women 19-44 years old with family incomes up to 185% of the Federal Poverty Level. The approved service cap is 200,000 women. MDCH is currently in the process of completing a continuation application for the Family Planning waiver, due in 2011.
/2012/ MDCH was granted an extension for the waiver by Centers for Medicare and Medicaid Services and is currently working to meet that deadline. //2012//

Other important focus areas of the Reproductive Health Unit are: promotion of "Prevention of Unintended Pregnancy in Adults 18 and Older" care recommendations, Maternal Child Health hotline oversight, prenatal smoking cessation promotion and training, and coordination with statewide sexually transmitted infection reduction efforts.
/2013/ MDCH is currently working under the waiver extension granted by Centers for Medicare and Medicaid Services. MDCH has applied for a Medicaid State Plan Amendment to expand Medicaid supported family planning and related services to men and women of child-bearing age up to 185% of the Federal Poverty Level.
Under the paragraph, "Other important focus areas of the Reproductive Health unit are: promotion of "Prevention of Unintended Pregnancy in Adults 18 and Older" care recommendations" add: "and Medicaid Administrative Outreach." //2013//
/2015/ MDCH is continues to work under the waiver extension granted by Centers for Medicare and Medicaid Services until June 30 2013. MDCH Medicaid Expansion "Healthy Michigan Plan" was approved and started implementation April 1, 2014. Any individual at or below 133% of the poverty level is eligible for Medicaid services which include family planning. Other important focus areas of the Reproductive Health unit are: promotion of "Prevention of Unintended Pregnancy in Adults 18 and Older" care recommendations and Medicaid Administrative Outreach."//2015//

The Perinatal Health Unit is the area within DFCH that is responsible for program activities, health promotion and prevention that focuses on the woman who is pregnant, between pregnancies and their newborn infant. The Perinatal Health Unit has the following objectives that guide their activities: increase the interconception health of women including prenatal and postnatal; reduce

infant mortality and morbidity; reduce maternal mortality and morbidity; eliminate disparities in infant and maternal birth outcomes; implement, support and evaluate a system of perinatal regionalization; increase the development of a medical home for women, particularly of child-bearing age; reduce untreated maternal depression; increase maternal/infant attachment for all women who give birth in Michigan; increase successful maternal health management for both women and their infants, including effective engagement in appropriate services and supports, particularly for women identified as being at-risk due to social/economic determinants of health; and increase screening for maternal alcohol use and implement prevention strategies to decrease the number of women who drink alcohol during pregnancy.

These objectives are accomplished by the provision of organized program, services and prevention activities. The following programs & services are coordinated within the Unit and incorporate culturally competent approaches:

Fetal Alcohol Spectrum Disorders (FASD) program provides prevention, awareness and access to services by: multidisciplinary teams called Centers of Excellence that diagnose children and provide initial care planning; community projects that provide local prevention and linking to services projects; and training and consultation that assist these agencies in their work. The outcome is to decrease this preventable disorder and enhance the quality of life for affected individuals /their families and lessen the social and economic impact of FASD in Michigan.
/2015/ The FASD boilerplate report was developed through joint efforts between Behavioral Health and Developmental Disabilities Administration and Public Health Administration and submitted to the state legislature April 1, 2014. The report addresses efforts to prevent and combat Fetal Alcohol Syndrome as well as deficiencies in efforts to reduce the incidence of Fetal Alcohol Syndrome. A report with recommendations and key strategies for an FASD work plan will be completed August 1, 2014. //2015//

Infant Mortality and Morbidity activities are designed for prevention and reduction of infant mortality/morbidity and elimination of racial disparities in infant death rates. The creation and implementation of the MDCH Infant Mortality Strategic Plan will help drive this process.
/2013/ In October 2011 an Infant Mortality Summit was held and seven priorities were developed from stakeholders input: Safe Sleep, Elimination of non medically indicated deliveries prior to 39 weeks, home visitation, unintended pregnancies, health disparities, progesterone protocol and perinatal regionalization. //2013//
/2014/ Eight strategies for infant mortality reduction includes seven priorities and better health staus of women and girls. An Infant Mortality consultant was hired February 2013 to coordinate activities to address the strategies. //2014//

Local Maternal and Child Health funds are flexible funds from the Federal Title V Maternal and Child Health Block Grant that are made available to local health departments to address locally identified health needs of women and children in their jurisdictions. Each local health department uses both a defined needs assessment process to determine/identify their MCH needs and also identifies which of the 18 priority MCH measures established by the MCH Bureau of the Department of Health and Human Services and eight/2012/ ten//2012// measures established by MDCH that their plan addresses.

Michigan Maternal Mortality Surveillance is a program of case ascertainment, surveillance of maternal death data and trends, case reviews and development of prevention recommendations based on analysis of data and case review findings to reduce Michigan's maternal deaths, illness and complications and decrease the black/white mortality ratio.
/2012/ Expected outcomes include: development of public health prevention recommendations that address health care policy; system change, and social and environmental conditions that will reduce Michigan maternal mortality and eliminate racial disparities in maternal death rates. //2012// /2013/ MMMS program completed a database which will allow vital records prepopulation by 10/2012. //2013//
/2014/ Completion of database with data from preventability and abstract forms by 10/2013.

//2014//
/2015/ The MMMS population-based state database has been completed. Data entry of case review records has begun and will link medical, injury and social determinant issues related to maternal mortality and women's health issues that occur within 365 days of a pregnancy. //2015//

/2015/ As part of the State's infant mortality reduction plan, the Perinatal Health Unit has joined the federal initiative, Collaborative Improvement and Innovation Network (CoIIN) a technology-enabled regional team tackling infant mortality in Michigan, Ohio, Illinois, Wisconsin, Indiana and Minnesota. The CoIIN to Reduce Infant Mortality engages regions in the full spectrum of change implementation -- from defining the problem and crafting an intervention, through implementing and evaluating the intervention and, finally, to the diffusing and adapting effective innovations in new settings. Region V is focusing on four strategies: safe sleep, social determinants, pre/ interconception health and early elective deliveries.

The Michigan Infant Mortality Reduction Plan update was convened in November of 2013 to provide an update on the Plan's progress and gather feedback from stakeholders statewide in moving the Plan forward. A final summary report of the Update will be completed and disseminated in the Fall of 2014.

The safe sleep bill, 4962 which promotes safe sleeping practices for parents of infant children signed on 5-14-14 requires hospitals to provide information to new parents about safe sleep practices and the risks of unsafe sleep practices. Hospitals must prescribe a form for parents to sign and if parents sign it to place it in the infant's medical record. The bill also requires DCH and DHS to coordinate on providing community-based services and educational efforts and materials on safe sleep practices and infant death due to unsafe sleep practices. //2015//

Maternal and Infant Health Program provides case management and support services to pregnant women and infants enrolled in Medicaid to improve maternal and infant birth outcomes.
/2012/ MIHP "redesign' continues in an effort to become an evidence based model. The program utilizes a standardized population management, care coordination approach with standards for adherence to model fidelity, streamlined paperwork & research based data collection. Quality assurance measures are in place to assure that services are consistently implemented in the varied programs throughout the state. //2012//
/2013/ Quasi experimental study to be concluded with report submitted by September 2012. //2013//
/2014/ Quasi experimental study of summary results available April 2013. Full report will be available after publication by researchers. //2014//

Medicaid Outreach/Access to Health Care allows for Federal match available to local health departments to support their local activities to facilitate outreach, public awareness, enrollment, access, monitoring and referrals for Medicaid services.

The Perinatal Health Unit has identified resources and methods to establish a formal perinatal care system as recommended by the Perinatal Regionalization Workgroup consistent with evidence based guidelines to clearly define levels of care designations and collaboration among regional hospitals providing services to women, neonates/infants and families to improve pregnancy outcomes. A nurse was recently hired to assume some of thes tasks required. The Unit collaborates and coordinates with many different groups to provide these services including: other State Departments; other Divisions within the Department of Community Health; local health departments; schools of medicine and public health; professional medical organizations; state wide organizations;hospitals;clinics;FQHCs; physicians; advocacy groups; culturally diverse community groups and interested stakeholders.
/2012/ MDCH is moving forward with plans for perinatal regionalization. Two pilot projects and a

designation survey for birth hospitals are in progress. The nurse consultant is assessing high risk birth hospital protocols. MDCH is a catalyst to create OB services in underserved portions of Michigan. //2012// /2013/ Five workgroups from September statewide meeting presented recommendations May 2012 for initiating Perinatal System of Care. Next step is hospital consensus and drafting of administrative rules. //2013//
/2014/ Perinatal Regionalization Administrative Team (PRAT) developed to coordinate and oversee regionalization activitities. AAP and ACOG 2012 Level of Care Guidelines endorsed by Chief Medical Officer. Neonatal Intensive Care follow up and Certificate of Need workgroup in process. //2014//
/2015/ CON Standards for NICU/SCN went into effect 3-3-14. NICU follow-up committee convened 3 workgroups to work on developmental assessment programing, NICU risk assessment & linkage of families to CSHCS & MIHP at delivery. //2015//

The Infant Health Unit is responsible for infant health promotion program & initiatives with objectives to:
Reduce fetal and infant deaths.
Reduce racial disparity in infant mortality.
Increase the percentage of infants sleeping in safe environments.
Increase the proportion of mothers who breastfeed their babies and increase lactation period.
Increase the percentage of employers who have worksite lactation programs.
/2012/ There are no longer Infant Health Unit program initiatives for lactation. //2012//
Promote "Routine preventive services for infants & children birth - 2 months.
Promote screening and evidence based treatment for known chronic conditions in newborns.
Increase the proportion of newborns that receive hearing screens no later than 1 month of age, audiologic evaluation no later than three months, and intervention services no later than six months. Increase early identification of physical, developmental and social-emotional issues and early linkage to appropriate follow up interventions.

Programs services and initiatives in the unit are:
The Early Hearing Detection and Intervention program is a process of screening, diagnosis, and intervention for newborns with congenital hearing loss. Universal newborn hearing screening is hospital-based aligned with efforts to establish and maintain a local comprehensive community-based system that provides screening, diagnosis and intervention services by the age of six months for infants who have been identified as having a potential hearing loss. The department provides education to local health care facilities on the importance of newborn hearing screening, the need for a collaborative local team for infants requiring follow-up, and maintains a statewide database for tracking screening and follow-up activities. Michigan Hands & Voices and the Guide By Your Side program, which provide support, resources and activities to families with a child who has hearing loss, are also supported under this program.
/2015/ The Early Hearing Detection and Intervention (EHDI) Program will be utilizing a quality improvement approach to test new strategies aimed at reducing the number of children lost to follow after failing a hearing screen or diagnosis of hearing loss. //2015//

The Safe Delivery program, by state law, allows for anonymous surrender of an infant (within 72 hours of birth) to an Emergency Service Provider without the expressed intent to return for the newborn, per the Michigan Safe Delivery of Newborns Act. A toll-free hotline exists to provide information to the public regarding the law, resources for counseling and medical services, and information on adoption services.

Infant Death Prevention and Bereavement services are provided through a contract with the nonprofit agency Tomorrow's Child. Tomorrow's Child develops and promotes initiatives for human service professionals that work with high-risk families; and develops bereavement counseling, education, advocacy and support services for families who have experienced the death of a young child. These services are promoted to medical examiners, hospitals, local health departments, FIMR teams and local child death review teams. Tomorrow's Child also provides promotion, education, and publication distribution regarding infant safe sleep under this

agreement.

The Infant Safe Sleep State Advisory Team is a public/private partnership that coordinates statewide efforts to implement Infant Safe Sleep and reduce infant deaths related to unsafe sleep environments. The Team includes representatives from the Department of Community Health, Department of Education, Department of Human Services, Michigan Public Health Institute and Tomorrow's Child. Formed in 2004 the Team works diligently to develop a statewide, consistent, comprehensive message and strategy to inform families and caregivers about unsafe sleep. An Infant Safe Sleep website was established, as well as an online training module.
/2015/ To support those impacted by a miscarriage, stillbirth or infant death, and promote preconception and interconception best practices, a bereavement counseling online training was developed so professionals are better prepared to offer grief services to parents and families in their community. //2015//

The Infant Death Autopsy Reimbursement program provides financial incentive to local medical examiner's systems to perform autopsy as well as death scene investigation in cases of Sudden Unexpected Infant Death. This program also provides surveillance of preventable infant deaths, especially post-neonatal and sleep-related deaths. Program objectives include the reduction of infant mortality by correctly identifying cause, manner and significant risk factors contributing to infant death, and standardization of how medical examiners certify cause and manner of SUID.

Michigan's Fetal Infant Mortality Review (FIMR) program identifies and examines factors that contribute to fetal and infant deaths through the systematic evaluation of individual cases. Multidisciplinary teams throughout the state work together to find patterns of need in a community and gaps in the perinatal health delivery system. The state FIMR coordinator provides technical assistance, consultation, and training of local teams. A single, state supported data system serves the teams.
/2012/ A CDC funded FIMR HIV Prevention Methodology project began in 2011. The project adapts the FIMR model to study cases of HIV + women who give birth in Michigan, for the purpose of identifying missed opportunities for preventing mother-to-child transmission of HIV. //2012// /2013/ The Infant Safe Sleep Advisory Team now includes the Children's Trust Fund (CTF) and Michigan Council for Maternal Child Health (MCMCH) as member agencies. A Request For Proposals (RFP) process will be conducted to select the contractor for Infant Death Prevention and Bereavement services in 2012. //2013//
/2014/ There are now two committees guiding the efforts to eliminate infant deaths caused by unsafe sleep environments. The Steering Committee involves select members from the Departments of Human Services and Community Health. The Advisory Committee has a broad membership of various state, regional and local representatives.//2014//

The Child Health Unit's purpose is to administer programs and initiatives that improve child wellness across all domains of development; increase family ability to understand and promote their child's wellness; support the development of an integrated and comprehensive early childhood system that spans public/private organizations and includes promotion, prevention, and intervention activities; and collect and analyze data to improve systems and service outcomes.

Programs and initiatives supported within the unit include preschool and school-aged Hearing and Vision Screening programs; Childhood Lead Poisoning Prevention; the Parent Leadership in State Government parent training initiative; and Project LAUNCH. The unit serves as liaison between Public Health and Part C/Early On Michigan which is administered out of our state Department of Education; interagency efforts to reduce abuse and neglect with our Children's Trust Fund and Department of Human Services; and with the MDCH Medical Services Administration and Michigan AAP regarding implementation of EPSDT. The unit also collaborates with both internal and external partners on initiatives to improve early childhood systems coordination, improve and expand home visitation services, /2012/ and the infrastructure to support such services, //2012// implement evidence-based practices and measure fidelity, support the integration of social-emotional well-being as a component of child wellness; expand

developmental screening; and increase the flow of information to the public that can support family and child wellness.
/2013/ In the past year, the Unit has added responsibility for leading the Michigan Maternal, Infant and Early Childhood Home Visiting Program and its system infrastructure building efforts, as well as a Primary Care Developmental Screening project. Both projects involve extensive collaboration with other internal and external partners, and represent significant opportunities to impact improvements in children's health and wellness in Michigan. //2013//
/2014/ If awarded, the Child Health Unit will take on the responsibility of leading the revised activities under the state's Early Childhood Comprehensive Systems grant. The Unit is taking a more active role in contributing to conversations and plans that will steer the future of the state's Great Start early childhood system and align activities across the system. The Unit is engaged in MDCH activities related to reforming the state's health care system, establishing community linkages hubs, and supporting implementation of family and patient-centered medical homes. //2014//
/2015/ In addition to adding capacity to lead the state's efforts around mitigation of trauma and toxic stress for young children and their families (ECCS grant), the Unit will also lead health-related activities for the state's new Race to the Top Early Learning Challenge grant. The new funds will help review existing child care licensing rules and standards as compared to those in "Stepping Stones to Caring for Our Children," help bring a wellness perspective to the state's Quality Rating and Improvement System, and build a cadre of Child Care Health Consultants based in regional child care resource centers with the intent of enhancing the quality of family and friend child care settings. //2015//

The Adolescent and School Health (ASH) Unit has a strong foundation in addressing a range of adolescent and school health issues through direct services and programming. Among the multiple adolescent health-focused programs coordinated by this unit are: Child and Adolescent Health Centers (school based health centers), Michigan Model for Health K-12 Comprehensive School Health Curriculum, the School Wellness Program (school nursing and mental health), a comprehensive Teen Pregnancy Prevention Initiative and Coordinated School Health Programs (in collaboration with the Michigan Department of Education).

The mission of the ASH Unit is to improve the health and well-being of Michigan's school-aged youth and young adults. The vision for ASH is that school-aged youth and young adults will transition into adulthood physically, emotionally and socially healthy; equipped with the necessary knowledge and skills to make informed decisions regarding their health and well-being; and able to locate resources and be active consumers in their health. ASH has many core objectives that guide its work, including:
•Supporting parents in understanding adolescent health issues;
•Improving access to care and a medical home for adolescents and young adults;
•Providing all children and youth with medically accurate information and best practices around health promotion and skill development;
•Improving access to mental health information, services and supports;
•Promoting healthy and informed decision-making around sexual health, including preconception health; and
•Supporting the identification of health, developmental and social/emotional concerns, through an integrated adolescent system of care at both the state and local levels.

To achieve some of these objectives, ASH operates the following statewide initiatives aimed at school aged youth:
- Child & Adolescent Health Centers are designed for school aged children and youth 5 through 21 years of age. These centers provide comprehensive primary care services, health education, peer counseling, screening/case finding services, referral for specialty care, and Medicaid outreach activities across 69 /2012/ 72//2012// /2013/ 69//2013// /2014/70//2014// locations in Michigan.

Michigan Model for Health is a nationally acclaimed comprehensive school health education

program that facilitates skills-based learning through lessons that include a variety of teaching and learning techniques, skill development and practice, and building positive lifestyle behaviors in students and families.
- Teen Pregnancy Prevention Initiative is a comprehensive pregnancy prevention program, whose goal is to reduce teen pregnancy in MI through the implementation of the evidence-based program, Safer Choices, in /2014/four//2014//eight ***/2015/six //2015//*** high need communities.

/2015/ The ASH Unit was successfully awarded $1,500,000 in federal Pregnancy Assistance Funds to develop an integrated service delivery system for pregnant and parenting teens 15-19 years of age, including teen dads, in five high need communities in Michigan. These communities include the City of Detroit, Benton Harbor, Lansing, Saginaw, and Wayne County. This is a four-year grant, with year one activities mostly focused on both state and local planning. A total of ten focus groups were conducted as part of this planning period, five among teen moms and five among teen dads. These focus group results, along with a comprehensive community service inventory, will be used to create community-specific integrated service plans which will drive service delivery to this population. //2015//

/2012/ -The Michigan Abstinence Program promotes abstinence from sexual activity and risky behaviors by providing relevant interventions that build peer pressure skills and promote personal respect and responsibility.
-Taking Pride in Prevention uses evidence-based models to educate adolescents on abstinence and contraception to prevent pregnancy and sexually transmitted infections. The programs must address healthy relationships, adolescent development and parent-child communication. //2012//

- Coordinated School Health Programs, in collaboration with the Michigan Department of Education, support an eight component model within the school district that includes school health, health education, physical education, health services, staff wellness, family and community involvement, healthy school environment, nutrition services, and counseling, psychology and social services.

The ASH unit has many strong collaborative partners at both the state and local level. However one unique partnership has developed with the Michigan Department of Education's Coordinated School Health and Safety Programs Unit. Because both Department's have an enduring commitment to the importance of adolescent well-being particularly when it comes to mental health and promoting social/emotional health, the Departments have created a "shared" state-level public health consultant position to focus exclusively on improving the social/emotional health of school aged youth in Michigan. This is just one example of this unique partnership between the MDCH and MDE.

The Oral Health Program within the division is responsible for education, promotion and implementation of activities and improving oral health throughout the life span for Michigan residents through prevention. Improving access to oral health includes oral health education, prevention of dental disease and dental restorative treatment. Through the efforts of the Oral Health Program, community water fluoridation programs are monitored for safety and effectiveness in reducing dental disease. Fluoride varnish programs and sealant programs offer oral health surveillance on all age children by detecting oral disease, applying preventive treatments, and referring for continued oral care. With the Count Your Smiles and Senior Smiles data collection we will better understand the oral health needs of school children and aging adults. Educating the public, medical and dental professionals as well as collaborating with other sections of the department in oral health has spread the word that oral health is integral to overall health.

Dental Hygiene PA 161 Program Allows a dental hygienist to work under relaxed supervision rules to provide service to the underserved children and elderly populations; must be a local, state or federal grantee health agency for patients who are not assigned by a dentist.

Oral Health Education and Access Promotion is a statewide oral health education program designed to change behavior, create awareness and improve the oral health of persons through all stages of life by linking oral health to total body health.

Points of Light Oral Health Program supports the matching of a dentist with a pediatrician to provide dental care to infants by age one. Educating the physician to do a caries risk assessment, provide anticipatory guidance and early dental interventions can greatly reduce dental disease in this young population.

Dental Treatment for Developmentally Disabled provides limited funding to assist the severe developmentally disabled population to access dental services; clients accepted for funding is through referral basis only from client case managers.

SMILE! Michigan Dental Sealant Program is a preventive dental sealant program offered to limited 2nd and 6th graders in schools with a high percentage of children enrolled in the Free and Reduced School Lunch Program. The program included an oral screening, placement of dental sealants on all erupted molar teeth, fluoride application, oral health education and referral for dental care.
/2012/ The school-based sealant program is now called SEAL! Michigan. The program expanded to an additional 15 schools for the past year. Another grantee in the Upper Peninsula was awarded a planning grant with implementation for the coming year. Continue discussions and planning to incorporate oral health as a component of the patient-centered medical home and health home grant opportunities. //2012//

Varnish! Michigan Program promotes fluoride varnish programs to reduce incidence of dental decay in primary teeth. Services are available to low income, high-risk 0-5 age children in medical facilities, Head Start and other vulnerable groups. Training on Infant/Child Oral Health is provided for MI Medicaid providers.

Volunteer Dental Program (Donated Dental) is a network of volunteer dentists providing dental care to persons who are mentally and physically handicapped, who are medically compromised, or who are elderly and/or indigent.

The Oral Health Unit collaborates and coordinates with many groups to provide these services including: other state departments; other divisions within the Department; professional medical organizations; state wide organizations; clinics; dentists; advocacy groups; Schools of Dentistry; culturally diverse community groups and interested stakeholders; hospitals; Federally Qualified Health Centers; schools; universities; health insurance plans; and pharmaceutical companies.
/2014/ The Oral Health Program has implemented a Perinatal Oral Health initiative related to providing better health status for women and girls. This initiative is targeted to provide improved pregnancy outcomes for mothers and reduced infant mortality rates. The initiative is to explore the national developments on perinatal oral health guidelines and to develop recommendations specific for Michigan. //2014//
/2015/ The Oral Health Program continues to promote all the activities from previous years that include school-based dental sealant programs, education and outreach, infant oral health program with fluoride varnish applications, community water fluoridation activities, dental hygiene workforce activities. The perinatal oral health (POH) initiative was implemented in 2013. A two day conference was held with national and state stakeholders attending. A summary of the conference was published with five objectives and a POH steering committee established. Work groups are being established to implement the objectives. The POH initiative works with a national partner to help develop a communication plan around this topic.

The Michigan Dental Program (Ryan White dental program for those individuals living with HIV/AIDS) was transferred to the Oral Health Program. The Michigan Dental Program provides access to dental care for those individuals eligible for the program. A dental

network is established to help individuals provide care.

Community water fluoridation is being monitored for those communities to fluoridate and the Oral Health Program is offering fluoridation equipment grants to communities who have not fluoridated their public water supply. //2015//

Services for Children with Special Health Care Needs

The Michigan Public Health Code, Public Act 368 of 1978 as amended, defines a CSHCS-eligible person as someone under age 21 "...whose activity is or may become so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support." Persons over age 21 with cystic fibrosis or hereditary coagulation defects (e.g., hemophilia) also may be eligible for services. CSHCS covers chronic physical conditions that require care by medical or surgical specialists. The program also evaluates severity, chronicity and the need to be seen at least once annually by an appropriate pediatric sub-specialist in making a medical eligibility determination. The full range of CSHCS program elements and services includes: case-finding; application for CSHCS coverage, assessment of family service needs, service coordination/case management, specialty medical care and treatment; family support services and opportunities for parent participation in policy development; and specialized home care supports.

The medical care and treatment covered by CSHCS includes a wide range of services such as physician specialist care, hospitalization, pharmaceuticals, special therapies, durable medical equipment, respite, and orthotics/prosthetics. In addition to making payment for these services, CSHCS assures quality in the services provided. Physicians, hospitals, and clinics must meet established criteria in order to qualify as CSHCS "approved" providers. The criteria focus on the demonstration of expertise and willingness to provide pediatric specialty services. Along with the approval of providers, CSHCS authorizes specific providers for each child, so that specialty expertise is appropriate for the child's condition. Provider reimbursement policies and rates are the same for both CSHCS and Medicaid.
/2014/ Starting October 2012, CSHCS clients that are currently enrolled in Medicaid Fee-for-service are transitioned into Medicaid Health Plans (MHP). There are some populations within CSHCS that are excluded or have the option but are not required to enroll. CSHCS has worked with the MHPs, state partners, and providers for several months prior to the change to ensure a smooth transition. By enrolling eligible clients into MHPs, CSHCS clients will receive better access to primary care and increased care coordination.//2014//

The payment agreement fee schedule has been changed to include all clients in a payment agreement on a sliding scale unless they have Medicaid, MIChild (CHIP) or WIC coverage if they choose to join CSHCS. This is a change from having those whose income is at or below 200% of the federal poverty level or for children adopted with a qualifying pre-existing condition being exempt from a payment agreement. /2012/ The payment agreement exemption for those who qualify for WIC was removed. All clients are now in a payment agreement unless they have Medicaid or MiChild (CHIP). //2012//

CSHCS is a statewide program, although certain program components may not be located in every county. For example, children's multidisciplinary clinics are associated with tertiary care centers, and family support coordinators may serve more than one county. Local health departments (LHDs) serve as a community resource to assist families in accessing needed services, both from CSHCS and other local agencies. LHD CSHCS professionals are encouraged to work closely with their MCH colleagues and with other agencies to identify community service needs from the perspective of children with special health needs and their families. These local collaborative efforts are supported by the state-level approach to community needs assessment and are reflected in efforts to remove artificial, categorical barriers to services. Local efforts are focused on the earliest intervention possible to prevent, cure or minimize the impact of handicapping conditions on children. In addition to program representation activities for the purpose of case-finding, the LHD system, the CSHCS Customer Support Section or the Family

Center helps families to obtain needed program information and services. Families are offered a Family Service Needs Summary by the LHD when the family requests assistance in understanding the CSHCS program and other services available in their communities. During the service needs summary, LHD professionals help to identify the needs of all family members. Service coordination can then be provided if the family decides it wants further help in developing self-advocacy skills, problem-solving, or in obtaining needed services.

The Family Center has parent consultants on staff and payroll to work closely with CSHCS, and provides parent membership in the CSHCS Advisory Committee, and the Family Support Network to reinforce family-centeredness. The CSHCS program operates according to the philosophies inherent in Family-Centered, Community-Based, Culturally Competent, Coordinated Care. This philosophy has been incorporated into all CSHCS strategies for program and policy development, and into the service delivery structure. CSHCS has built an infrastructure that assures both input and feedback with regard to these critical program characteristics. Formal relationships with local health departments, initiatives to strengthen home-based care, and provider standards all support a community-based approach. Coordinated care is facilitated by state-level inter-agency planning (including coordination among state-level parent support initiatives); local relationships among and between other MCH colleagues and human service agency professionals; broad representation on the CSHCS Advisory Committee; and expectations of specialty clinic providers, primary care physicians, and local health department professionals.

The CSHCS strategic planning meeting that engaged stakeholders in the process of preparing a five-year plan for the CSHCS program to address the implementation of the MCHB Healthy People 2010 objectives resulted in the establishment of workgroups to begin to address the priorities that the strategic planning meeting identified. (See Needs Assessment, page 13.)

The Family Center has three major areas of responsibility: 1) development of a statewide, community-based network of parent-to-parent support, 2) provision of parental input to CSHCS administration regarding programs and policies; and 3) facilitation of timely responses to families in need. As a core component of the CSHCS organization, the program is headed by a parent of a child with special health needs. The program is unique in that it is inclusive of all families of children with special health care needs, whether or not they are enrolled in CSHCS. The Children's Special Health Care Services hotline is operated through the Family Center.

All children eligible for SSI are also eligible for Medicaid in Michigan. Therefore rehabilitation services are typically provided under Title XIX, often in the school under Medicaid-Reimbursed School-Based Services. Michigan Medicaid has a very extensive benefit package, and the need for further coverage would be rare. CSHCS provides medical services as needed based upon the CSHCS qualifying diagnosis. Therefore, CSHCS would provide medically necessary services not covered under Title XIX for children enrolled in CSHCS.

C. Organizational Structure

The Title V program is administered by the Bureau of Family, Maternal and Child Health, Public Health Administration, Michigan Department of Community Health. The Bureau includes Divisions of Family and Community Health, WIC, and Children with Special Health Care Services. The Title V Director is the Director of the Bureau who reports to the Director of the Public Health Administration. The Public Health Administration also includes the Bureau of Epidemiology, the Bureau of Health Promotion and Disease Control and the Bureau of Laboratories. The Bureau of Epidemiology maintains the state's vital records system and provides the Title V program with data and analytical support. The Department of Community Health reports directly to the Governor.

The Division of Family and Community Health manages programs within the areas of reproductive health, perinatal health, infant health, child health, adolescent and school health and

oral health. This includes Family Planning, Prenatal Smoking Cessation, Fetal Alcohol Syndrome Prevention, Infant Mortality and Morbidity, Maternal Mortality and Morbidity, Maternal and Infant Health Program, Pre/Interconception Health, Local Maternal & Child Health, Early Hearing Detection & Intervention, Medicaid Outreach/Access to Health Care, Safe Delivery, Safe Sleep, Fetal Infant Mortality Review, Child Lead Poisoning Prevention, Early On, Hearing Screening, Vision, Screening, Parent Leadership in State Government, Child & Adolescent Health Centers, Coordianted School Health, Michigan Model for Health, Teen Pregnancy Prevention Initiative, Michigan Abstinence Program, and Oral Health.

Because the WIC program reaches so many low-income families, it is integral to many of our MCH efforts including promotion of immunization, lead poisoning screening, nutrition and breastfeeding. More than half of the infants in the state are seved by the WIC program.

Children's Special Health Care Services provides medical care and treatment, care coordination, case-finding, assessment of family service needs, family support services and other ancillary services for children with special health care needs and works closely with the Medical Services Administration in providing specialty services for Medicaid-eligible families and coordinating with primary care services.
An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The department does not provide direct services, but contracts with local health departments and other community health agencies to provide MCH services. Local health departments are units of local government. The 45 local health departments in Michigan employ over 5,500 staff including nurses, physicians, nutritionists, social workers, sanitarians, health educators and epidemiologists. Department staff provide training, consultation and technical assistance to local health departments and other community providers in various programs, certify providers of the Maternal and Infant Health Program, determine eligibility for CSHCS program, plan and develop programs, projects and new initiatives, and monitor the performance of local programs. Most of the staff at the state level working on maternal and child health programs are located in the Bureau of Family, Maternal and Child Health which includes the Divisions of Family and Community Health, WIC, and Children's Special Health Care Services. The Bureau Office has two professional and one clerical position. The Bureau is part of the Public Health Administration within the state Department of Community Health. All state staff are located centrally in Lansing.

Alethia Carr is the Title V Director and Director of the Bureau of Family, Maternal and Child Health. Ms. Carr has an MBA and a Bachelor of Science degree in hospital dietetics and is a registered Dietitian. She has ten years experience as a clinician and more than 25 years of management experience in various maternal and child health programs including childhood lead poisoning, MCH HIV/AIDS, and Women's and Reproductive Health.
/2015/Effective February 1, 2014, Rashmi Travis became the Director of the Bureau of Family, Maternal and Child Health and the Title V Director for Michigan. The previous Title V Director, Alethia Carr, retired September 1, 2013, and Stan Bien became Acting Director until the position was filled on a permanent basis. Ms. Travis served as the Health Officer for Allegan County in southwestern Michigan for twelve years. She has a Bachelor of Arts Degree in Communications/Public Relations and a Bachelor of Science Degree in Microbiology from the University of Michigan and a Master of Public Health from the University of Pittsburgh Graduate School of Public Health with a concentration in maternal and child health.//2015//

In the Division of Family and Community Health, there are 56 established positions including four vacancies. In addition there are fourteen professional contractual staff working on numerous programs and projects. Professional staff is composed of nurses, public health consultants, hearing and vision consultants, nutrition consultant and managers. Brenda Fink, A.C.S.W., is the Director of the Division and has served in that capacity since 2003. Prior to that, she was a

manager in the Long Term Care program, serving as Acting Director from 2000-2003; and served in several capacities with Kalamazoo Community Mental Health Services, including Chief Operating Officer and Deputy Director of Systems and Operations, Co-Acting Director, Director of Family Services, and Children's Services Coordinator.
/2012/The Division currently has 60 established positions including 13 vacancies. There are also 19 professional contractual staff.//2012//
/2013/ There are currently 45 filled positions in the Division, including 6 clerical positions. There are nine vacant positions at the present time.//2013//
/2014/There are 45 filled positions in the Division and eleven vacancies.//2014//

The WIC Division administers the federal Supplemental Food Program for Women, Infants and Children and Project FRESH. The Division has 43 funded positions, including six vacancies. Staffing includes nutritionists, public health consultants, analysts and managers. Stan Bien is the Director of the WIC Division. Mr Bien has 25 years of management experience, including 22 years with the WIC Division. He has a Bachelor's of Science degree in Accounting and a Masters degree in Public Administration.
/2013/ The WIC Division currently has 36 filled positions, including 6 clerical positions. Of the ten current vacant positions, two are section manager positions.//2013//
/2014/The WIC Division has 34 filled positions and thirteen vacancies.//2014//

The Children's Special Health Care Services Division currently includes 46 funded full time positions including one vacancy. Professional staff is made up of doctors, nurses, nutritionists, analysts and managers. Support staff perform clerical, technical and enrollment functions. Parents of children with special needs, working through the Family Center for Youth and Children with Special Health Care Needs perform an advisory role to the department as well as developing support networks across the state for parents of special needs children. The Family Center currently employs eight staff total, five of whom are parents of children with special needs.
/2013/ THe CSHCS Division currently has 36 filled positions and ten vacant positions.//2013//
/2014/In the Children's Special Health Care Services Division, there are 36 filled positions and fifteen vacancies.//2014//

Kathleen Stiffler is the Director of the Children's Special Health Care Services Division. Ms. Stiffler has over 24 years of experience in various capacities within the Maternal and Child Health area, including over seven years as the director of Michigan's Children and Youth with Special Health Care Needs Program. As the CYSHCN Director, Ms. Stiffler has overseen a significant effort along with the Division's many partners, to move the state closer to meeting the 2010 objectives for CYSHCN. This included a comprehensive strategic planning effort in 2008 that included over 100 partners. Progress has been made since that time on all six 2010 objectives. Additionally, Ms. Stiffler oversees the operations of the CSHCS program that provides insurance coverage and support services to over 30,000 children and youth with special health care needs. Before accepting the CYSHCN position, she served as the Unit Director for Adolescent Health for over eight years. In that capacity she was responsible for directing program and policy development, program implementation and monitoring, quality assurance, evaluation and program improvement for Michigan's adolescent health programs. The focus of adolescent health programming in Michigan includes school-based/school-linked teen health centers (primary care programs designed to address the unique needs/strengths of the adolescent-aged population) and teen pregnancy prevention. Prior to that, Ms. Stiffler was the Chief of the Prenatal and Infant Care Section. Ms. Stiffler holds a Master's Degree in Health Education and is currently on the Board of Directors for the Association of Maternal and Child Health Programs.
/2012/Effective May 16 2011, Richard Cummings became the Acting Director of the Children's Special Health Care Services Division. Mr. Cummings has been with the Division for nineteen years, the last thirteen as Director of the Customer Support Section of the CSHCS Division responsible for reviewing and approving program eligibility applications, payment agreements, and client coverage changes. Prior to joining the Division he served in various financial management capacities with the Michigan Department of Public Health. He has a Bachelors Degree in Accounting. Mr. Cummings will serve as Acting Director of the Division until his

retirement at the end of June. In the meantime, the process of permanently filling the Division Director's position is ongoing.//2012//
/2013/ Lonnie Barnett was appointed Director of the Chidlren's Special Health Care Services Division in August 2011. Mr. Barnett has 20 years of state and local experience in health assessment, health planning, primary care systems development, workforce development and the uses of data to inform and develop policy. He was employed as a community health planner for the Kent County Health Department in Grand Rapids, Michigan, and, previous to his appointment as CSHCS Division Director, was Manager of the Health Planning and Access to Care Section of the Michigan Department of Community Health. He has a Master of Public Health degree from the University of Michigan and completed undergraduate studies in Biology and Economics at Emory University.//2013//

The Office of Medical Affairs within the Medical Services Administration houses two full-time physician consultants dedicated specifically to CSHCS, and three physicians who dedicate a portion of their efforts toward CSHCS needs. Their role is determination of program eligibility, approval of CSHCS specialists, and approval of specific specialists to serve the CSHCS beneficiary.

The Bureau of Epidemiology, Division of Lifecourse Epidemiology and includes a Maternal and Child Health Section with seven positions (three vacancies). This section works with staff of the Bureau of Family, Maternal and Child Health on data collection, analysis and evaluation. The Newborn Screening Unit has six professional staff. This unit follows up on newborn screening tests and results with hospitals, physicians and parents.

E. State Agency Coordination

The Michigan Department of Community Health includes the Medical Services Administration (responsible for the Medicaid and MIChild programs), Mental Health and Substance Abuse Administration, Public Health Administration, Services to the Aging, and Health Policy and Regulation Administration (responsible for licensing of health professionals and facilities). In administering the Medicaid and MIChild programs, DCH works closely with the Department of Human Services, the state agency responsible for eligibility determination for Medicaid and other assistance programs.

Directors of the Departments of Community Health, Education, Human Services, Corrections and Energy, Labor and Economic Growth meet on a regular basis to coordinate policy and discuss cross-cutting issues affecting our common clients. Most recently, each department has identified their top priorities that require interagency coordination of policy and activities. The Department of Community Health has identified infant mortality as our interagency priority; Human Services -- poverty; Corrections -- Michigan Prisoner Re-entry Initiative; Energy, Labor and Economic Growth -- No Worker Left Behind; and Education -- Education Reform.
/2012/At this point in the new Governor's administration, the Interagency Directors meetings have been put on hold while the new department directors get settled into their roles and the state's budget is being worked out.//2012//
/2013/ The Interagency Director's group has been replaced by the People Group, including the Departments of Community Health, Education, and Human Services.//2013//

In addition to the projects mentioned above, other interagency efforts include projects addressing healthcare workforce issues (Interagency Healthcare Workforce Coordinating Council, Michigan Opportunity Partnerships, Governor's Accelerated Health Career Training Initiative), Autism Spectrum Disorder Workgroup, and Foster Youth Development Program. The workforce initiatives will address current and predicted critical health care worker shortages in the state, particularly nurses and physicians, by expanding educational opportunities and re-training workers and by offering online information to healthcare employers and career seekers. The

Autism Spectrum Disorder Workgroup developed recommendations to the Directors in regard to early identification, appropriate treatment and education. Two pilot sites to implement the recommendations on screening, assessment and evidence-based practice interventions and evaluation of results began in October 2008. The Foster Youth Development Program helps youth transitioning out of foster care to achieve independent living status by assisting them with education and employment goals, housing, and learning how to access and use the health care system.

DCH and the Department of Human Services continue to work together on outreach activities to low-income families eligible for public programs. The Department of Human Services (DHS) provides information and helps families apply for Medicaid and MIChild, determines Medicaid eligiblity and updates relevant information for Medicaid beneficiaries. DCH and DHS collaborate on policies and processes for making low income families aware of their eligibility for public assistance programs through various state and local sources, particularly families leaving the TANF program due to increased income or noncompliance with work requirements. DCH and DHS also collaborate on family preservation efforts, the Safe Delivery program targeting new mothers who may want to surrender their babies, and the Child Death Review Program. Both departments maintain representation on the State Child Death Review Team.
/2013/The Department is working with the Children's Trust Fund to include the ACE (Adverse Childhood Experiences) module in Michigan's 2013 BRFSS. This module contains questions related to such topics as physical and emotional abuse, substance use in the home, sexual abuse, violence between adults in the home, and incarcerated member of the household that may lead to negative adult health outcomes.
In addition, DCH and DHS are working together to update public messages regarding Safe Sleep to focus on infant suffocation deaths.//2013//
/2014/DCH is participating in an interagency steering team, led by the Department of Human Services, to address infant suffocation deaths. A work plan has been developed that includes identification of evidence-based programs and best practices, addressing the social determinants of health, increasing public awareness of the issue and risks, and engaging community, professionals and business to promote safe sleep practices. New educational materials and videos have been developed and a plan for distribution, in addition to posting on state web pages, will be developed.//2014//

DCH and the Department of Education collaborate on school health programs and work together on the Early On initiative (Part C of IDEA). The activities of the Early On program are directed by the State Interagency Coordinating Council and include technical assistance and training for local coordinating councils. Staff from the Division of Family and Community Health, the Division of Mental Health Services to Children and Families, and CSHCS participate on the state council. The departments also cooperate in administering the Youth Risk Behavior Survey and the School-based Health Centers and in the design and implementation of the Michigan Model health education curriculum. DCH works with the Department of Education to develop plans for assisting schools not meeting performance expectations under No Child Left Behind, and to support a "shared" public health consultant position to focus on the social/emotional health of school-age youth.
/2014/The Department worked with the Departments of Education and Human Services and the Early Childhood Investment Corporation to develop a new grant proposal for early childhood comprehensive services in 2013.//2014//
/2015/A new grant award for Early Childhood Comprehensive Systems was approved by HHS on August 9, 2013. Michigan chose to focus on Strategy 1: The mitigation of toxic stress and trauma in infancy and early childhood. This strategy was chosen because of its potential to improve social and emotional development, address conditions that contribute to disparities, improve quality and availability of early childhood services via system development, and use a collective impact approach to improve and integrate activities.//2015//

DCH joins with the Departments of Agriculture and Environmental Quality in developing and

implementing the Michigan Local Public Health Accreditation Program. This program institutes a baseline standard for characteristics and services that define a local health department. The program includes a self-assessment and on-site review components and is operated on a three-year cycle. DCH contracts with the Michigan Public Health Institute to house, staff and coordinate the program. More information on this program can be found at www.accreditation.localhealth.net.

The Title V Director is the Department's liaison with the Michigan Women's Commission. The two agencies partner on issues affecting women in the state, such as infant mortality, unintended pregnancy and domestic violence. The Title V Director also serves as a member of the Michigan Pandemic Influenza Coordinating Committee (PICC) and Chair of the Human Health Committee. The PICC coordinates pandemic flu activities vertically and horizontally across state agencies.

The Title V program participates in an ad hoc workgroup that has been convened within the Department to coordinate and share information on several medical home projects in the department, including Chronic Disease, Medicaid and CSHCS.

The Michigan Public Health Institute, a non-profit corporation, was authorized by Public Act 264 of 1989 as a cooperative venture of the Michigan Department of Public (now Community) Health, the University of Michigan, Michigan State University and Wayne State University to plan, promote and coordinate public health research, evaluations and demonstrations. The Institute's board of directors includes representatives from each of the universities and the department. Since its creation, the Institute has worked with the department on several important initiatives including: evaluation (e.g., Maternal Support Services, Michigan Abstinence Partnership, Local Public Health Accreditation Program); developing new programs and projects (e.g., Suicide Prevention, child death review teams); training and technical assistance activities (e.g., development of a standard tool for reporting death scene investigations of sudden and unexplained child deaths and training of local child death review team members); and data collection and reporting (e.g., child death review database, PRAMS).

With the statewide implementation of Medicaid managed care in 1998, EPSDT services were integrated into the qualified health plans (QHPs). Most local health departments no longer provide EPSDT services. The MCH program continues to work with the Medical Services Administration to develop standards of performance and quality for the plans and provides technical consultation. The MCH program also provides training for QHPs and local health departments on the hearing and vision components of EPSDT.

In 2008, the Department of Community Health convened the Michigan State Leadership Workshop to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On. For the short-term, six priority areas were identified: use data to help assure access and quality; using Medicaid managed care to serve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups were formed to explore actions and recommendations in each of these areas. Follow-up on priorities identified at the Michigan State Leadership Workshop is taking place through Michigan's Early Childhood Comprehensive Systems interdepartmental advisory body, the Great Start Systems Team. Medicaid has worked with the MI Care Improvement Registry (MCIR) to add fields to document delivery of EPSDT services. /2012/Due to budget cuts and staffing limitations, the Leadership Workshop was disbanded. However, activities to achieve the intent of the Workshop continue to be pursued through other

means, e.g., MCIR augmentation, medical home project, CSHCN managed care.//2012//

The protection of the public's health under the Public Health Code is a partnership between the state and local health departments (LHDs). The state health department has responsibility for general supervision of the interests of the health and life of the people of Michigan, promoting an adequate system of community health services throughout the state, and developing and establishing arrangements and procedures for the effective coordination and integration of all public health services, including effective cooperation between public and non-public entities to provide a unified system of statewide health care. With the responsibility for many personal care services including maternal and child health services shifted from local public health to qualified health plans, the role of local health departments has changed somewhat to emphasize assurance of community capacity to provide needed services and accountability for the health status of the community. LHDs continue to carry out the core functions and to provide services aimed at communicable disease control, protection of food and water supply, casefinding and service coordination and planning for children with special health care needs, health education and public information. In addition, the LHDs provide a link to other social and public services. The state health department supports the local health system with funding, training, technical assistance and data resources.
/2013/ Due to a critical financial situation, the Mayor of the City of Detroit has proposed elimination of the city's health department. A proposal to turn over the responsibilities of the city health department to a public nonprofit agency, the Institute for Population Health, effective October 1 2012, has been advanced and is being considered by the City Council. Under the Public Health Code, Detroit is not required to operate a health department. Another option is for Wayne County to take over responsibility for public health activities within Detroit. The Department of Community Health is working with Detroit officials to assure that the citizens of Detroit will have access to essential public health services.//2013//
/2014/The Institute for Population Health was created as a public non-profit agency to assume the local public health services for the City of Detroit. The Institute began providing services in October 2012.//2014//
/2015/Due to legal concerns, some core services will be pulled back into the City of Detroit health department. The plan is to directly manage essential local public health services (hearing and vision screening, immunizations, communicable diseases, STD/HIV) and to contract for other services including WIC and Children's Special Health Care Services.//2015//

WIC is part of the Bureau of Family, Maternal and Child Health and continues to be an important component of strategies to improve the health of pregnant women, mothers and children. WIC clinics routinely make referrals for lead screening, Maternal and Infant Health Program, and prenatal smoking cessation. The clinics also routinely check immunization status and either refer or provide immunizations on site. Outreach activities are coordinated through the MCH hotline.

Availability and accessibility of family planning services is a key strategy for reducing unintended pregnancy and teen pregnancy. State and federal resources are combined to assure that women and men in need of family planning services have access to them through a provider of their choosing and through referral arrangements with prenatal care providers, WIC and substance abuse programs. In 2006, approval of a Section 1115 Family Planning Waiver expanded Medicaid-covered family planning services to women 19-44 years old with family incomes up to 185% of poverty. Family planning services are a required component of capitated funding for Medicaid enrollees in qualified health plans. The QHPs are also required to reimburse other publicly funded family planning clinics for family planning services provided to any QHP enrollee. The Division of Family and Community Health provides continuing education and training to Title X family planning clinics and managed care providers. The Family Planning program also works with the Breast and Cervical Cancer Control Program (BCCCP) to provide follow-up diagnosis and testing for women who had an abnormal Pap test from Family Planning services. This group of women is too young for the services of the traditional BCCC program.
/2015/Michigan's Plan First Family Planning program (Medicaid Section 1115 waiver) is

being phased out by the Department. This program covered family planning services for women beyond the postpartum period. The assumption is that coverage can be obtained through either Medicaid or through the health insurance exchanges.//2015//

There are currently six Healthy Start programs in Michigan - Kalamazoo, Flint, Detroit, Grand Rapids, Saginaw and Sault Sainte Marie. The department created a collaborative network of all programs to share their experiences, discuss issues of mutual concern and interest, and to develop standardized evaluation criteria for the programs. The network meets approximately four times a year. The department also assists proposed new programs with their applications by providing data and technical assistance and supports an extensive program evaluation project involving four of the projects (Detroit, Grand Rapids, Sault Sainte Marie and Flint). /2014/The Ingham County Health Department was recently added as the seventh Healthy Start project in the state.//2014//

The implementation of Medicaid managed care has significantly changed the role of local health departments and the MCH program in assuring access to prenatal care. Qualified health plans are held accountable by contract for providing prenatal services in accordance with standards set by the Medicaid program. A separate organization is contracted to conduct enrollment activities. The Medical Services Administration is responsible for administering the managed care contracts, establishing performance standards, monitoring and evaluating performance. MSA contracts with the Health Services Advisory Group, Inc. to conduct annual performance reviews of all plans.

Many local health departments (LHDs) and community agencies continue to provide enrollment and outreach services to low-income women either through agreement with the QHP(s) in their area or with their own resources. Several have had to limit their activity due to funding constraints by reducing staff dedicated solely to enrollment and outreach or by concentrating on the non-Medicaid eligible low-income population. Local health departments are encouraged to partner with community agencies to extend the scope of their efforts.

The Parent Leadership in State Government project identifies, trains and supports parent leaders from among families who utilize specialized public services provided through DCH, Education, Human Services and/or their local counterparts, with a focus on providing consumer voice and input on local, state and federal program planning and policy development that impacts children and families.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	34.0	29.6	25.6	22.7	22.7
Numerator	2093	1765	1498	1305	1305
Denominator	616055	596286	584390	575714	575714
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
2013 data are not yet available.

Notes - 2012
2012 data are not yet available

Narrative:
MDCH epidemiology and chronic disease receive a CDC Asthma grant. Aof the many grant activities (surveillance, provider education, system of care coordination, and policy), the most immediate impacts on 0-4 year olds is an intensive in home asthma case management program.

Michigan's in-home case management model (MATCH) program, started in 1996, is sustained through reimbursement contracts with health plans. MATCH programs currently cover eight of 10 high burden counties, five of which have densely populated high-asthma burden areas (Ingham, Genesee, Muskegon, Washtenaw, and Wayne). MATCH is a nationally recognized, guidelines-based care model with self-management education at its core for adults and children with moderate to severe asthma. Six home visits by an AE-C teach self-management skills, along with environmental assessments, and school, day care, or work visits as appropriate. Social workers consult to address psychosocial issues. A face to face physician care conference allows for update or creation of a useful asthma action plan and simultaneously reinforces guidelines-based care. Communication and care coordination are also built into the MATCH model: physician care conferences, along with letters and phone calls to the physician and health plan, are integral. Case managers frequently contact health plans to request and receive approval for additional home visits if needed to address multiple caregivers or psychosocial challenges. A 2013 multi-site MATCH evaluation documented the model is replicable and sustainable, with significant reductions in inpatient hospitalizations (83%), ED visits (60%), missed school days (58%) and work days (45%).

MDCH asthma staff successfully expanded MATCH program since 2009 to serve over 2000 children and adults with severe asthma in predominantly high-burden counties (total population reach of 4 million people). Over the last couple of years, asthma has partnered with the Environmental Healthy Homes Section to conduct a HUD technical study pairing MATCH activities with healthy home policy and training activities in low income housing complexes in Ingham County. The Ingham Health Department conducts MATCH, using PH nurses who have AE-C. This also allows for better coordination with other services the family may be receiving. Ingham's recently signed a reimbursement contract with a health plan, adding to the sustainability of the model. Wayne County's CHAP program has also begun implementing the MATCH program for families with young children.

In the coming year, MDCH asthma staff will work to get the program running in Saginaw County and expand services in Wayne through additional partners.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	78.6	82.5	81.3	82.3	82.7
Numerator	56068	57891	58366	57872	58497
Denominator	71293	70193	71834	70331	70736
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
MDCH worked with Part C Early On, MI-AAP, M- AFP, & Great Start to improve developmental screening (DS) & referral to Part C by providers. The Primary Care Developmental Screening project (PCDS) trained providers & staff to integrate DS into practice. PCDS funding ended; new resources are being sought. The training will continue with FQHCs through Project LAUNCH funding.

Maternal, Infant & Early Childhood Home Visiting (MIECHV) funded home visiting (HV) sites continue to provide DS, data collection & reporting on indicators related to DS. MIECHV uses ASQ 3 & ASQS/E to monitor children's development. MIECHV continues to expand HV services in 11 high risk communities through an Expansion grant. Also, a state funds expansion may move forward focusing on rural northern MI areas. Two MIECHV funded local implementing agencies are engaged in the HRSA HV CoIIN & focusing on DS & referral; lessons learned will be shared with other HV sites & models.

MI received an Early Childhood Comprehensive Systems grant to build early childhood leadership work stream for aggregating, aligning, & reporting statewide early childhood data that aligns with MIECHV benchmarks. The Great Start early childhood administrative structure convenes the Great Start Operations Team (GSOT), a team of mid-level managers that provide oversight for collaborative grants/activities. This team is beginning a root cause analysis to understand the policies, funding, & other potential barriers that the state will need to address as it moves toward centralized data collection & information sharing related to DS & results.

The state continues to plan to address linkages between the health care community & community-based services as part of its CMS State Innovation Model (SIM) grant. If MI receives additional grant funding, an opportunity to establish a DS pathway could be realized; this would improve screening, track data, assure referrals are made & linkages are achieved, & to explore funding mechanisms that align with the goals of health care reform & the Triple Aim. Efforts to build an early childhood data system also continue to move forward, supported by a new Race to the Top Early Learning Challenge grant, & a grant from the W.K. Kellogg Foundation.

The state's evidenced based home visitation program-Maternal Infant Health Program (MIHP) assists over 55,000 pregnant women & infants annually with accessing care. Literature (Megha, 2013) describes the effectiveness of the state wide program show that MIHP improves maternal prenatal/postnatal care & infant care & reduces the risk for adverse birth outcomes (prematurity, extreme prematurity, LBW, VLBW) with particular advantage for African American women. A key infant finding is that infants whose mothers were enrolled in MIHP were more likely to present for any well-child visits, & were more likely to have the appropriate number of well-child visits over the first year of life.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**

Annual Indicator	71.4	77.2	72.1	70.7	62.9
Numerator	235	227	204	203	195
Denominator	329	294	283	287	310
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
MDCH has worked with Part C Early On, MI-AAP, M- AFP, & Great Start to improve developmental screening (DS) & referral to Part C by providers. The Primary Care Developmental Screening project (PCDS) trained providers & staff to integrate DS into practice. The funding for this project has ended, and new resources are being sought. However, via resources that were provided through Project LAUNCH, training will continue with FQHCs.

Maternal, Infant & Early Childhood Home Visiting (MIECHV) funded home visiting (HV) sites continue to provide DS, data collection & reporting on indicators related to DS. MIECHV uses ASQ 3 & ASQS/E to help monitor children's development. MIECHV continues to expand HV services in 11 high risk communities through an Expansion grant. Additionally, expansion with state funds may move forward with a focus on rural areas in northern Michigan. Two of the MIECHV funded local implementing agencies are engaged in the HRSA HV CoIIN and focusing on developmental screening and referral; lessons from their efforts will be shared with other home visiting sites and models.

MI received an Early Childhood Comprehensive Systems grant to build early childhood leadership work stream around aggregating, aligning, & reporting statewide early childhood data that aligns with MIECHV benchmarks. The Great Start early childhood administrative structure convenes the Great Start Operations Team (GSOT), a team of mid-level managers that provide oversight for collaborative grants/activities. This team is beginning a root cause analysis to understand the policies, funding, and other potential barriers that the state will need to address as it moves toward centralized data collection and information sharing related to developmental screening and results.

The state continues to plan to address linkages between the health care community and community-based services as part of its CMS State Innovation Model (SIM) grant. Should Michigan receive additional grant funding, an opportunity to establish a developmental screening pathway could be realized; this would improve screening, track data, assure referrals are made & linkages are achieved, & to explore funding mechanisms that align with the goals of health care reform & the Triple Aim. Efforts to build an early childhood data system also continue to move forward, supported by a new Race to the Top Early Learning Challenge grant, and a grant from the W.K. Kellogg Foundation.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	72.1	74.1	74.5	74.0	72.7
Numerator	84061	84767	85077	83428	81840
Denominator	116610	114401	114159	112708	112503

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The percent of live births with adequate or adequate plus by Kotelchuck Index is 72.7% in 2013. The annual indicator remains relatively unchanged over the past five years.

Access to adequate prenatal care is an important strategy in improving birth outcomes for both mother and baby. Over 1/3 of mothers of newborns who resided in several counties in central northern Michigan, southwest Michigan and several counties in the UP received less than adequate prenatal care. The access to care issues in rural counties in Michigan is a concern that state policymakers have noted. Efforts to develop and implement regional perinatal care systems are in development.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	50.5	55.1	56.1	57.0	58.3
Numerator	115850	130959	134231	137389	142389
Denominator	229388	237583	239243	241225	244141
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The Healthy Kids Dental program was expanded to an additional three counties, effective for the new fiscal year of October 1, 2013. This program is now in 78 of 83 counties serving approximately 525,000 children. The Healthy Kids Dental program, which is the Medicaid dental managed care program administered by Delta Dental Plan of Michigan, continues to provide access to oral health care for Medicaid enrollees by using their dental network. The utilization of dental services in these 78 counties continues to increase above 50 percent and is greater than the overall statewide utilization of 34 percent.

The SEAL! Michigan school-based dental sealant program has nine grantees due to the combination of Title V monies and a Delta Dental Foundation grant. The number of schools being served increased from 160 to over 225 schools in FY13. In FY12, 18,365 were placed on 6170 students.

The SEAL! Michigan school-based dental sealant program contracted with new agencies for a

three year cycle beginning in October, 2013. The SEAL! Michigan program has eight contracted sites utilizing Title V and Delta Dental Foundation monies.

The SEAL! Michigan program implemented a branding campaign called the SEAL OF APPROVAL PROGRAM (SOAP). Four agencies that previously received grant funds became self-sustaining. The Oral Health Program developed and initiated a memorandum of agreement with the agencies so that in return for data, the Oral Health Program provides technical assistance and helps with oversight. So, the SEAL! Michigan and SOAP programs have 12 school-based dental sealant programs providing sealants in school-based or school-linked settings.

The Oral Health Program was awarded a HRSA Workforce grant and one component was to develop a SEAL! Michigan program with dental hygiene students in the rural community surrounding Ferris State University. This program is still in the development stage.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2013	payment source from birth certificate	9.3	7.4	8.3

Narrative:
In 2013 the percent of LBW was 8.3%. The percent of Medicaid births that were LBW is 9.3%. The percent of non-Medicaid births that were LBW is 7.4%. There is a higher percent of LBW infants born to women who have Medicaid.

Families in poverty have higher rates of low birth weight and subsequent health and developmental problems. Policies strengthen opportunities for low-income families are needed to lesson LBW infants. Examples include job training opportunities for high school graduates to build skills necessary to earn family-sustaining wages, decreasing pay equity gap in Michigan to help female-headed households, raising the minimum wage, and supporting the successful implementation of Healthy Michigan Plan (ACA). Additionally, there are serious inequities in poverty which disproportionately affect racial/ethnic minorities. Data regarding social determinants of health in addition to income level needs to be consistently and systematically collected.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

Infant deaths per 1,000 live births	2012	payment source from birth certificate	8.4	5.7	7

Narrative:
Michigan's Infant Mortality Rate has recently demonstrated a decline over the past decade with the exception of 2007, yet remains higher than the national rate of 6.05. Although the infant mortality rate had begun to decrease in Michigan from 7.1 per 1,000 in 2010 to 6.6 per 1,000 in 2011 there was a slight increase in the rate to 6.9 per 1,000 in 2012. According to provisional data, the 2013 rate of infant deaths mirror that of the 2011 rate declining slightly to 6.6 per 1,000. While preliminary data reveals a notable decrease in the African American infant mortality rate from 13.5 per 1,000 in 2012 to 11.9 per 1,000 in 2013, disparities still persist however. Moreover, the American Indian infant mortality rate increased significantly from 9.3 per 1,000 in 2011 to 14.1 per 1,000 in 2012. Additionally, the infant mortality rate among African American and American Indian infants remains more than twice the state rate and more than 2.5 times higher than the infant mortality rate of White infants in Michigan.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2013	payment source from birth certificate	64	80.6	73.2

Narrative:
The percentage of births with prenatal care in the 1st trimester varied by source of payment, age, race, and ancestry of the mother. In 2012, 74.4% of women received care in the 1st trimester, with 66.0% of Medicaid and 81.3% non-Medicaid. Women who were teens were less likely to receive prenatal care in the first trimester (<15 year was 25.7%, 15 -- 19 years was 57.7%). White women were more likely to receive prenatal care in the first trimester than black, American Indian, or Asian and Pacific Islander women in all age categories. The same is true of Arab and Hispanic ancestry. The following are the total women by race with a live birth who receive prenatal care beginning in the 1st trimester: white 77.8%, black 62.3%, American Indian 72.7%, Asian and Pacific Islander 75.4%, Arab 70.2% and Hispanic 67.0%. In 2013, preliminary data indicate 73.2% of women received care in the 1st trimester, with 64.0% of Medicaid and 80.6% non-Medicaid. Like the previous two years, white women were more likely to receive prenatal care in the first trimester than black, American Indian or Asian and Pacific Islander women.

The trend data of women having live births who received prenatal care prior to the 4th month of pregnancy remains flat and there has been little progress in in the trend in over 40 years. There was a dip the percent receiving prenatal care prior to the 4th month in 2008 that has persisted through 2012. Rates are consistent with rates seen in the mid 1970s. In 2010, according to Michigan Pregnancy Risk Assessment Monitoring System (PRAMS), the percentage of women covered by Medicaid increases as women move from pre-pregnancy (26.2%), to prenatal (41.8%) to delivery (46.6%). There is also racial disparity in insurance coverage. The percentage of Black, Non-Hispanic women covered by Medicaid was consistently the highest for pre-pregnancy insurance status, payment for prenatal care and delivery. Disparities among women receiving care in the 1st trimester reflects a disturbing trend.

Women, according to PRAMS, report a variety of barriers to accessing prenatal care including that they didn't know about the pregnancy, they couldn't get an appointment, provider or health plan wouldn't start, didn't have enough money, didn't have Medicaid card, had too many other things going on, didn't want others to know about pregnancy, didn't have transportation, didn't have child care. Policies for access to care across the lifespan, with a health equity lens, are needed.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2013	payment source from birth certificate	66.8	80.7	72.7

Narrative:
In 2013 72.7% of women had adequate or adequate plus prenatal care by Kotelchuck Index. There is a socioeconomic and racial disparity. Non-Medicaid births had greater adequacy of prenatal care (77.6%) than Medicaid births (66.8%). White women had greater adequacy/adequacy plus prenatal care (76.6%) than black women (59.7%).

Inadequate prenatal care is often cited as a risk factor for infant mortality. In 2010 in Michigan, infants born to mothers with inadequate prenatal care died at a rate of 16.8 infants per 1,000 live births, which was 2.9 times greater than infants with adequate prenatal care. The Michigan Health Equity Status Report -- Focus on Maternal and Child Health released in 2013 gives further insight in to the state of inequity in Michigan as of 2010. Policies for access to care across the lifespan, with a health equity lens, are needed.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
	3	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files		
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2015

Narrative:
Michigan has access to the majority of the database resources identified in the MCH block grant. Michigan's Executive Information System/Decision Support System and a data warehouse with multiple years of data from Medicaid, WIC, CSHCS and Vital Records provides the ability to link different data sets and thus track the impact of population participation in MCH programs. The system includes the online provider services, real time claims adjudication and improved services to clients.
State vital records (live births records, death certificates, linked infant mortality file by either birth or death cohort, fetal deaths) remain an important source for monitoring pregnancy outcomes. The CoIIN supplemental funds in States Systems Development Initiative (SSDI) grant supported development of 'near real time' infant mortality reporting to provide MCH programs with timely data to inform MDCH's Infant Mortality Reduction plan and HRSA's Region V CoIIN.
Michigan continues to use Michigan Inpatient Database (MIDB) linked to the live birth file for analysis of maternal, perinatal and neonatal morbidity, most notably for Neonatal Abstinence Syndrome Surveillance (NAS) and Early Elective Delivery.
The Michigan Medicaid claims database, within the Michigan data warehouse, has been used along with immunization data to determine the prevalence of influenza and TDAP immunization among pregnant women in Medicaid.
The Pregnancy Risk Assessment Monitoring System (PRAMS)is an important source of information about pregnancy outcomes and risks prior to and during pregnancy for MCH programs and only estimate of unintended live births. Results are used to monitor the health of women and infants, inform interventions and develop health policy. Michigan's Native American PRAMS survey, collaboration between MDCH, the Intertribal Council and the Kellogg Foundation, is in its second year of data collection. For the first time, data about the health of Native American women and infants will be available to inform State and Tribal communities.
The Michigan Maternal Mortality Surveillance Database (MMMSB), restored in 2014, includes linked data from vital records, abstracted data from prenatal, hospital, provider and investigation records, review committee findings and recommendations, and an estimate of level of preventability.
Planning for a PRAMS Follow-up Survey is underway with SSDI grant funding. The target

population is Michigan mothers of toddlers who participated in the PRAMS survey and agreed to be contacted.
The SSDI grant partially supports a MCH epidemiologist position in the Bureau of Epidemiology, who provides technical support to MCH programs. MCH Epidemiology capacity creates sustainable infrastructure to improve data quality, efficiently measure health outcomes and develop life course metrics, as well as the foundation for continued system and outcomes evaluation, assisting Title V programs in to improve health of women, infants and children.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes
NYTS	2	Yes
YTS (2015)	3	Yes

Notes - 2015

Narrative:
A report in the CDC MMWR, September 2013, states that e-cigarette experimentation and recent use doubled among U.S. middle and high school students during 2011--2012, resulting in an estimated 1.78 million students having ever used e-cigarettes as of 2012. Moreover, in 2012, an estimated 160,000 students who reported ever using e-cigarettes had never used conventional cigarettes. This is a serious concern because the overall impact of e-cigarette use on public health remains uncertain. Additionally, a CDC study just published (April 2014) finds that the number of calls to poison centers involving e-cigarette liquids containing nicotine rose from one per month in September 2010 to 215 per month in February 2014.

Trend analysis also indicates that with the new ACA and expansion of Medicaid in Michigan, the percentage of customers who smoke is near -- or perhaps above 50% of total enrollment. This presents both a strategic opportunity and numerous logistical challenges for providers and insurers to appropriately address tobacco use with clients and create systems changes to ensure that tobacco users get access to the support they need to quit.

Of pressing priority for the Tobacco Program is the issue of e-cigarettes and their impact on not only smoking initiation (gateway to smoking?) but on the problem of ‘dual use' (use of conventional tobacco products and e-cigarettes inter-changeably). This is a priority issue now in Michigan because the legislature is debating the best way to regulate e-cigarettes and similar smoking devices. The Department has favored defining and regulating e-cigarettes as tobacco products.

Providing effective and adequate services to new Medicaid enrollees through the ACA Medicaid expansion is also a priority. Medicaid is seeking support and expertise on how to address tobacco use among smokers as an essential health benefit. The Tobacco Program is working closely with Medicaid to implement payment systems and treatment systems to respond to improving patient health.

Outcomes for success in addressing e-cigarettes: state legislation or FDA regulation that define e-cigarettes and treat e-cigarettes as "tobacco products".

Outcomes for success in addressing Medicaid expansion and tobacco dependence systems change include: increased number of appropriate referrals to the Quitline, increased numbers of

quit attempts demonstrated by the Quitline , increased utilization by health care systems of the 7 approved medications to support quit efforts, and increased utilization of individual face-to-face and group counseling.

IV. Priorities, Performance and Program Activities

A. Background and Overview

For the 2011-2016 period, five of the previous priorities were retained (some wording changes):

Increase the proportion of intended pregnancies

Increase the proportion of CSHCN population that has access to a medical home and integrated care planning

Reduce obesity in children, including children with special health care needs, and women of child-bearing age.

Address environmental issues (asthma, lead poisoning and second-hand smoke) affecting children, youth and pregnant women.

Reduce African American and Native American infant mortality rates.

Little to no consistent progress on reducing infant mortality and its associated risk factors (low birth weight, preterm birth and unintended pregnancy) has been made over the last five years. In addition, there is still great disparity in infant mortality rates among racial and ethnic groups. Activities to address these indicators for the next five years will focus on pre- and inter-conception health, social determinants of health and health behaviors. See NPM #01, NPM #08, NPM #15, NPM #17, NPM #18, SPM #02, SPM #03, and SPM #04.

The Children's Special Health Care Services Division developed a 2010 Action Plan for Children with Special Health Care Needs which included, for each national performance measure, an identification of gaps in policies, analysis of quantity and quality of services, and prioritized recommendations for action. Implementation of the plan is ongoing, including several medical home pilot programs and transition planning for youth with special health care needs. See NPM #2-6.

Activities to improve the health status of children and youth will continue to include cooperation and coordination with other DCH programs (Chronic Disease, Injury Control, Mental Health and Substance Abuse, Medicaid), other state agencies (Education, Human Services, Corrections, and Energy, Labor and Economic Growth), and other stakeholders (Michigan Dental Association, Delta Dental of Michigan, Michigan State Medical Society, March of Dimes, Michigan State University, etc.). Three new priorities will focus on reducing rates of sexually transmitted diseases among youth, increasing access to early intervention services and developmental screening, and increasing access to dental care. See NPM #07, NPM #09, NPM #10, NPM #11, NPM #12, NPM #13, NPM #14, NPM #16, and SPM #05.

/2013/ Statewide summits focusing on two of the Governor's Dashboard measures -- obesity and infant mortality -- were held in 2011. From the infant mortality summit, seven strategies were recommended to reduce the overall infant mortality rate in Michigan and the disparity in infant mortality rates between racial and ethnic groups: 1) implement a statewide regional perinatal system; 2) promote adoption of "Hard Stop" policies to reduce medically unnecessary deliveries before 39 weeks gestation; 3) promote adoption of progesterone protocol for high risk women; 4) promote safer infant sleeping practices to prevent suffocation; 5) expand home visiting programs to support vulnerable women and infants; 6) support better health status of women and girls; and 7) reduce unintended pregnancies.
/2015/An eighth objective was added to the final Infant Mortality Reduction Plan issued by the Department in 2012: to weave the social determinants of health into the other seven objectives of the plan to promote the reduction of ethnic and racial disparities in infant mortality. In 2013, we continued to work with our partners from academia, advocacy, health care providers, professional organizations, local health departments and other state departments to implement the strategies outlined in the Plan. See Needs Assessment Summary section for more information.//2015//

In September 2011 a statewide summit on obesity was held to engage stakeholders from across

the state the development of actions to reduce the obesity rates among the population overall and children. From the summit recommendations, the Department developed the "4 X 4 Plan" with the following strategies and goals:

Maintain a healthy diet	Body Mass Index
Engage in regular exercise	Blood Pressure
Get and annual physical examination	Cholesterol level
Avoid all tobacco use and exposure	Blood sugar/glucose level

A. Develop multimedia public awareness campaign to encourage every resident to adopt health as a personal core value through promotion of the 4 X 4 Plan
B. Deploy 46 community coalitions throughout Michigan to support implementation of the 4 X 4 Plan
C. Engage partners throughout Michigan to help coalitions implement the 4 X 4 Plan: employers, trade and other professional organizations; education system; and departments of state government.
D. Within MDCH, create the infrastructure to support 4 X 4 Plan implementation energizing the local coalitions and partners.
Within these strategies, the MCH program will promote breastfeeding as a means of reducing childhood obesity and the 4 X 4 Plan among women of childbearing age.//2013//

B. State Priorities

Increase the proportion of intended pregnancies
According to the Pregnancy Risk Assessment Monitoring Systems (PRAMS), less than half of the pregnancies in Michigan are intended. Intendedness of pregnancy has consequences for maternal health and pregnancy outcomes, as well as economic consequences. Services to support activities related to this priority include family planning (Title X and Medicaid) and Teen Pregnancy Prevention Initiative. Related Performance Measures are NPM #08 and SPM #01.

Increase the proportion of CSHCN population that has access to a medical home and integrated care planning
Children with special health care needs have complex medical problems that require care and services from multiple providers who are frequently not located in close proximity. Often, there is a lack of communication between providers and no focal point for coordination of care. Lack of coordination may cause the condition of already medically fragile children to deteriorate or fail to improve. Several projects are underway to develop or pilot medical home models, including the Department of Pediatrics Henry Ford Health System Cooperative Project, MCAAP Residents Training, and the CSHCS State Implementation Grant. Related Performance Measure is NPM #03.

Reduce obesity in children and women of child-bearing age, including children with special health care needs.
Data for Michigan residents indicate that rates of obesity for children and adults are increasing. Programs to address this issue include nutrition education through Child and Adolescent Health Centers, Michigan Model, WIC and the Michigan Nutrition Network. The Michigan Steps Up and Generation with Promise programs, developed and operated by Michigan's Surgeon General, promotes healthy eating and physical activity in school-age children and the general population. The Department of Community Health and the Title V program are also partners in the Healthy Kids, Healthy Michigan initiative with the Michigan Chapter of the American Heart Association and approximately 100 other organizations to plan and implement activities designed to reduce and prevent childhood obesity. Related Performance Measure is NPM #14.

Address environmental issues (asthma, lead and second-hand smoke) affecting children, youth and pregnant women.
Lead poisoning is a continuing priority in Michigan, with Black children disproportionately affected.

Asthma is one of the leading causes of preventable hospitalization for children. 15.9% of mothers statewide and 31.2% of Native American mothers were exposed to second-hand smoke at home. Programs to address these environmental issues include the Childhood Lead Poisoning Prevention Program, Child and Adolescent Health Centers, Michigan Model, and the Prenatal Smoking Cessation program. Other programs outside of the Title V program address asthma through the Asthma Coalitions in Detroit, West Michigan, Genesee and Saginaw and MDCH Healthy Homes University Program. Related Performance Measures are NPM #15 and SPM #05.

Reduce African American and American Indian infant mortality rates.
According to Michigan Vital Records, Black infants died at 2.7 times the rate for white infants and Native American infants died at 1.5 times the rate for white infants. Black infants were more than twice as likely to have low birth weight as white infants and have higher preterm birth rates. Services to address issues impacting infant mortality include Medicaid-covered services (prenatal care, delivery, neonatal care), Medicaid Outreach, Maternal and Infant Health Program, Safe Delivery, Safe Sleep, FIMR and Maternal Mortality Surveillance. Related Performance Measures are NPM #01, NPM #08, NPM #15, NPM #17, NPM #18, SPM #01, SPM #02, SPM #03, SPM #04 and SPM #10.

Decrease the rate of sexually transmitted diseases among youth 15-24 years of age
Chlamydia rates for 15-19 year-olds increased by 110.6% from 2000 to 2008, and gonorrhea rates increased by 38.5% for the same age group and time period. In addition to the services administered by the Bureau of Epidemiology Communicable Disease Section, Family Planning, Child and Adolescent Health Centers and Teen Pregnancy Prevention Initiative offer services to address sexually transmitted diseases. Related Performance Measure is SPM #06.

Reduce intimate partner and sexual violence
One of the factors affecting maternal depression is exposure to intimate partner and sexual violence. According to the Youth Risk Behavior Survey (YRBS), 12.4 % of high school students experienced dating violence in 2007, and 10.3% were forced to have sexual intercourse they did not want. The incidence of violence is significantly higher among Native Americans. Title V services to address this priority are included in the Maternal and Infant Health Program and the Child and Adolescent Health Centers. Related Performance Measure is SPM #08.

Increase access to early intervention services and developmental screening within the context of a medical home for children
Early identification and treatment of health and development problems in young children can prevent or mitigate the lifelong affects and improve the child's chance of success upon entering school. Programs to address this priority include CSHCS multi-disciplinary clinics, regional perinatal system, Early On, Great Start Collaborative (Early Childhood Comprehensive System), and the ABCD Project. Related Performance Measures are NPM #01, NPM #03, NPM #04, NPM #05, NPM #12, NPM #17 and SPM #09.

Increase access to dental care for pregnant women and children, including children with special health care needs
Oral health can affect other diseases/conditions and may place pregnant women at risk for pre-term births and low birth weight. In addition, other diseases, such as diabetes, can affect an individual's oral health. According to our Medicaid database, less than 50% of children 6 through 9 years of age received any dental service during 2008. Children with special health care needs especially have difficulty finding a provider. Thirty-nine of Michigan's 83 counties are designated dental Health Professional Shortage Areas. Related Performance Measure is NPM #09.

Reduce discrimination in health care services in publicly-funded programs.
All of the data indicators that were reviewed as part of the needs assessment demonstrated disparity between rates for the white population and other racial/ethnic groups. The Community Conversations series, hosted by the Health Disparities and Minority Health Section of the Public Health Administration, noted a distrust of health care professionals among minority communities

and issues of cultural sensitivity and language barriers. A concerted effort to address these disparities must be made if we are to achieve improvements in health status indicators for the maternal and child health population. Related Performance Measures are NPM #08, NPM #11, NPM #13, NPM #15, NPM #18, SPM #01, SPM #02, SPM #03, SPM #04, SPM #05, SPM #06, SPM #07, SPM #08, SPM #10.

While the MCH program has lost significant state funding over the past two years for programs targeting infant mortality and pregnancy prevention, support is still provided to local programs in the form of data and consultation. In addition, the MCH program works with other MDCH programs and other state agencies to coordinate efforts aimed at our mutual target populations. Wherever possible, other funding sources are identified to maintain some level of service in these programs. For example, state funding support for five Nurse Family Partnership projects was eliminated in the FY 2009 budget. However, some of the local sponsors have been able to retain the Medicaid match with local funding sources. In addition, the Patient Protection and Affordable Care Act will enable us to restore and expand programs that address several of our priorities for the next five years.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	220	277	219	256	244
Denominator	220	277	219	256	244
Data Source	NBS Program data	NBS Program data	NBS Program Data	NBS Program Data	NBS Program data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

During 2013, 112,486 newborns were screened and 244 were diagnosed with one of 51 disorders. Communication with hospital based NBS coordinators continued including provision of quarterly Quality Improvement reports based on hospital performance measures of number of

unsatisfactory, late, early and batched specimens. Other quality assurance measures evaluated were the number of cards recorded on the electronic birth certificate and the number of Michigan Bio-Trust forms received with the consent for research section correctly filled out.

Five contracts were maintained for medical management of cystic fibrosis and metabolic, endocrine, hemoglobin and immunodeficiency disorders. The NBS Technical Advisory Committee recommended that CCHD and Pompe Disease be added to the Michigan NBS panel and the MI legislature's NBS Quality Improvement Advisory Committee voted to add these disorders to the panel with screening to begin for CCHD April 1, 2014 and for Pompe Disease on October 1, 2016.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve birthing hospital performance relative to proper NBS specimen collection and submission.		X		
2. Maintain or increase the rate of screening and verify the number of newborns screened through linkage with vital records			X	
3. Improve screening performance for specific disorders as needed by examining metrics and recommending algorithm changes			X	
4. Increase the number of infants who receive appropriate short and long term follow up for a positive new born screening test			X	
5. Obtain baseline data and develop strategies to reduce the proportion of children diagnosed with a disorder through NBS screening who experience developmental delay requiring special education services		X		X
6. Obtain baseline data and develop strategies to improve the care of children diagnosed with heoglobinopathies diagnosed through NBS screening		X		X
7.				
8.				
9.				
10.				

b. Current Activities

Michigan NBS staff continues to particpate in the CDC Hemoglobinon Transfusion Surveillance Project, Region 4 Genetics Collaborative and other national efforts related to NBS data sharing and quality improvement. Staff are involved in development of reports on implementing NBS for additional Lysosomal Storage Disorders and Adrenal Leukodystrophy. The NBS Technical and Quality Assurance Advisory Committees will continue to review screening evidence to assess whether to add one or more of these disorders to the MI NBS panel thoughout this calendar year.

c. Plan for the Coming Year

1. Continue to implement CCHD screening in conjunction with the CCHD Advisory Committee and the Society of Thoracic Surgeons Data Committee with the goal of completing electronic reporting of all CCHD screening results to the NBS LIMS system for evaluation of the Detection rate, Positive Predictive Value and False Positive and Negative Rates of the screening algorithm.
2. Complete and evaluate a new protocol for assuring that all MI birthing hospitals minimize the turn-around-time for receipt of NBS specimens by the NBS laboratory.
3. Continue to develop plan for providing access to medically necessary foods and supplements for lifelong treatment of inborn errors of metabolism.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**112486**					
Reporting Year:	**2013**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	112021	99.6	15	5	5	100.0
Congenital Hypothyroidism (Classical)	112021	99.6	997	89	89	100.0
Galactosemia (Classical)	112021	99.6	15	9	9	100.0
Sickle Cell Disease	112021	99.6	74	52	52	100.0
Biotinidase Deficiency	112021	99.6	94	17	17	100.0
Cystic Fibrosis	112021	99.6	459	33	33	100.0
Other Amino Acid Disorders	112021	99.6	31	8	8	100.0
Other Fatty Acid Oxidation Disorders	112021	99.6	76	14	14	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	112021	99.6	127	5	5	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	112021	99.6	10	5	5	100.0
Other Severe Combined Immunodeficiency (SCID)	112021	99.6	77	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	56.4	56.4	56.4	74.5	74.5
Annual Indicator	56.4	56.4	74.5	74.5	74.5
Numerator					
Denominator					
Data Source	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010	NS-CSHCN 2009-10	NS-CSHCN 2009-10
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	74.5	74.5	74.5	75	75

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT

comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The Family Center for Children and Youth with Special Health Care Needs (Family Center) is the parent-directed
section of the Children's Special Health Care Services division (CSHCS). The Family Center is an integral part of the division. The Family Center provides services to families statewide and serves as the collective voice for all families.
The information the Family Center receives from families is used to provide consultation to Michigan Title V programs regarding policy and program development. All written materials intended for families created by CSHCS, as well as CSHCS policy and procedure, are reviewed by the Family Center for recommendations or revisions. The Family Center also provides review of the federal MCH Block Grant application.

An important service the Family Center provides to families is the toll-free Family Phone Line. The Family Phone Line is available to families who have children with special needs throughout the state of Michigan, whether they are enrolled in CSHCS or not, meeting the broader definition of special health care needs as outlined by the MCHB. The Family Phone Line is used to assist families in accessing providers, obtaining information on the CSHCS program, and general information and referral for families of children with special needs. In 2012, the phone lined handled 19,000 calls. In an effort to be culturally competent and accessible to all families, the Family Phone Line subscribes to a Language Line to increase access for individuals who do not speak English. In 2012, approximately 27 calls used the language line, primarily for translation into Spanish and Arabic. In 2012, the Family Center had stopped the Heart-to-Heart newsletter to combine with the Family to Family Health Information and Education Center newsletter "Family Linkages".

The Family Center also continues to provide parent support through their statewide family support network of
Michigan. This network matches support parent volunteers with other parents in similar situations in need of
support. In 2012, the Family Support Network made 106 parent matches and held 3 support parent trainings
providing services across the state of Michigan for parents with children with special health care needs. The Family Center provides conference scholarships for youth and family to attend conferences around the United States that pertain to their diagnosis.

In 2012, two mini-grants were awarded to local health departments that established a family advisory committee, developed a local newsletter, and expanded the Parent Network.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Center provided review of CSHCS materials, policy, and correspondence, as well as the Title V Block Grant.		X		X
2. Handled 20,000 calls through the Family Phone Line.		X		
3. Matched parents through the Family Support Network of Michigan.		X		
4. Held trainings for support parents through the Family Support Network of Michigan.		X		

5. Redesigned the Biennial Relatively Speaking Conference to regional community based family conferences held multiple times per year.		X		
6. Provided scholarships for families and youth to attend the educational conferences related to the clients diagnosis.		X		
7. Provided mini grants to local public health departments to use for family partnership activities.		X		
8. Trained families and professionals through Family to Family Health Information Center trainings.		X		
9. Provided training and outreach to community organizations.				X
10.				

b. Current Activities

The Family Center is currently involved in the appeals process for CSHCS enrolled families who appeal decisions
made by the division. Family Center staff is the first line contact for families and are often able to find information
about the unique situation that provides resolution for the family, avoiding a lengthy administrative appeals process.
The Family Center works closely with the "Innovative Strategies" and "Integrated Community Systems" grants by
providing parent leadership support and training.

The Family Center revised the former Relatively Speaking conference, which will now be held as annual community-based Family Conferences to support integration and inclusion within the local community. Two Family Conferences were held in 2013. The focus of these conferences was on care coordination, transition planning, and the ACA for CYSHCN. A sibling workshop was held concurrently with the Family Conference.

In 2013, nine mini grants were awarded to local health departments for the purpose of increasing family
participation at the local level. With the funding the Family Center provided to our local health partners the following counties were able to accomplish family activities such as; hired parents to plan events, create newsletters, develop service quality surveys, and conduct focus groups and needs assessments. The Family to Family Health Information and Education Center has been moved to another organization; we plan to reestablish the Family Center newsletter.

c. Plan for the Coming Year

The Family Center will continue to provide consultation to the Michigan Title V programs, as well as keeping existing services to families that include:
•The Family Phone Line
•A statewide family support network
•Conference scholarships for parents and young adults to learn more about diagnosis, care and advocacy.
•In service training for families, children's hospitals, Medicaid HMO's, Local Health Departments, and other agencies
•Trainings to parents and professionals in collaboration with the Family to Family Health Information Resource
Center.
•Provide outreach and education to organizations, schools, clubs, etc. about the CSHCS program and its benefits.
•Mini-grants may continue to be awarded to local health departments in 2014 that aim to strengthen the
communication, outreach, and family involvement.
•Host and facilitate two Parent Mentor Trainings

In 2014 the Family Center may hold two additional conferences at new locations in the Lower Peninsula. The current plan is to hold two to four conferences per year on current topics in different regions of the state. This will allow for community-based involvement and support for more families of children and youth with special health care needs.
These changes in location and format will allow easier access for families. We will support families with travel
allowances and day care support. We will also evaluate each session utilizing a valid tool developed in conjunction with the Child Health and Evaluation Research Unit (CHEAR) at the University of Michigan, Ann Arbor.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46	46	46	43.7	43.7
Annual Indicator	46	46	43.7	43.7	43.7
Numerator					
Denominator					
Data Source	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010	NS-CSHCN 2009/10	NS-CSHCN 2009-10
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	43.7	43.7	43.7	44	44

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

2011 saw the end of the three year HRSA-funded, Michigan's Integrated Community Systems of Care for Children
and Youth with Special Health Care Needs project. The projects aim was designed to support the implementation
of the six core components of a system of services for children and youth with special health care needs
(CYSHCN). Implementation was being supported through the establishment and regionalization of the medical
home model throughout the State of Michigan. Over the three years of the project, 14 practices around the state
were recruited to participate as Family Centered Medical Homes. The practices were located in urban and rural
areas; they were large and small, public and private. Diverse practices were chosen in order to have a range of
practice-based experience to guide the development and evolution of pediatric family-centered medical homes in
Michigan.

At the end of the project an evaluation was conducted. The Medical Home Index (MHI) was used as a tool for
practices to assess their own areas of strength and needed improvement. From Time 1 to Time 2 ratings, 10 of 12 practices (83%) showed an increase in the overall LEVEL of MHI rating across all categories. Personnel from 13 practices participated in structured interviews at both the beginning and end of their participation in the
demonstration project. Ten practices felt they had a strong likelihood of sustaining the medical home activities
initiated through this demonstration project. Ten practices felt their project activities had a substantial, positive

impact for patients with special health care needs and their families.

Eight practices noted that participation in the demonstration project had a positive impact on the practice itself.
To continue the spread and sustain the medical home model pilot, the division was awarded a new HRSA-funded
Integrated Systems for CSHCN grant on September 1, 2011. The new grant project, Michigan's FQHC Medical
Home Model for Children and Youth with Special Health Care Needs HRSA D70MC23050, continues to spread the
family-centered medical home model to a Federally Qualified Health Center (FQHC), the Alcona Health Center, in
rural Northeastern Michigan. The project began September of 2011. A project coordinator is supported by grant
funding and staff is working with the Alcona Health Center, a large FQHC system serving three Michigan counties
and two community based school health centers. With grant funding the project coordinator is continuing to
develop a registry of all CYSHCN. Also under continuing development is a community based resource system of
support. The project coordinator conducts outreach into the community to link organizations and their resources
for CYSHCN. In 2012 staff conducted a Parent-2-Parent Training in the Alpena area. This training provided. In
2012 progress continued on the HRSA grant, H98MC20273, Awareness and Access to Care for Children and Youth with Epilepsy. The purpose of the project is to assure that access to the best quality of health care services is available to children and youth with epilepsy in designated rural and medically underserved areas of Michigan with the use of telemedicine.

Accomplishments:
1. 11 pediatric telemedicine sites are running monthly pediatric epilepsy clinics.
2. Patient/family satisfaction is 100% rating the telemedicine clinics.
3. The originating site, the site where the patient and family are located, is the Pediatric Medical Home for each
child/youth with epilepsy.
4. Care Coordination is provided within the medical home setting.
5. Provider satisfaction, at both the primary care physician and the pediatric sub-specialty sites, are rated at 97%.
6. One additional site will be operational by August 1st, 2013

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partnered with large FQHC in rural Michigan, Alcona Health Center, to implement and spread the medical home model. There are currently 201 children and youth in the patient registry, which is in on-going development.		X		X
2. Established 11 pediatric telemedicine sites running monthly pediatric epilepsy clinics.	X	X		X
3. The program continues to support the development of the MiPCT projects.		X		X
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Michigan's FQHC Medical Home Model for Children and Youth with Special Health Care Needs and Awareness and
Access to Care for Children and Youth with epilepsy grant projects are currently working with the Alcona Health
Center, a FQHC. Both current HRSA grant projects have partnered with the Family Center to coordinate family
advisory activities within the medical home. In addition to their partnerships with the Family Center, both projects work with local health departments, local Early On programs, the local Community Mental Health program, and local school districts to enhance the access to community based resources and further the coordination of care.

The Michigan Primary Care Transformation (MiPCT) demonstration project is a state-wide project to support care
coordination within medical home sites and encourage further medical home site development in pediatric and family practices across the State. The project focuses on the advanced primary care practice (patient-centered medical home) model. The project has a steering committee for implementation, which includes Jane Turner, MD, the CSHCS Medical Home Physician Consultant.

c. Plan for the Coming Year

Sustainability plans for the current HRSA grants have been integrated into the grant work plans from the beginning of the grant funding cycle. Awareness and Access to Care for Children and Youth with Epilepsy, the telemedicine grant, was organized to be a sustainable interoperable telemedicine network with the development of each site.
Michigan FQHC HRSA grant will be sustainable. The funding for the current grant cycle will provide the initial support for the project coordinator. The FQHC then was able to build into their budget process the funding to sustain this valuable position beyond grant funding.
One of the identified priority areas of the 2011-2016 Title V Needs Assessment is ensuring CYSHCN have a medical home. "In order to more effectively address the complex needs of CYSHCN, the establishment of a medical home is critical to the coordination of primary and specialty services. Efforts will continue to define and implement the medical home concept for CYSHCN in Michigan. Early intervention and developmental screening services will allow children to develop to their full potential and enhance their learning ability." Children's Special Health Care Services will be working closely with our partners in public health and Medicaid to ensure that the large scale patient centered medical home projects taking place across the state include children and youth with special health care needs and their families.
The Awareness and Access to Care for Children and Youth with Epilepsy grant is planning to expand its services
beyond Epilepsy to include rheumatology, obesity, endocrine and gastrointestinal services. In addition, this grant
will continue to recruit additional specialties, collaborate with Epilepsy Foundation of Michigan, and explore
opportunities to develop the telemedicine model of health care delivery.
September, 2013 Michigan was awarded a second HRSA grant: Michigan's Approach to Improving Access to Services for Children and Youth with Epilepsy (CYE). This grant cycle is September, 2013 -- August, 2016. This grant will: 1. continue to expand telemedicine services for CYE in rural and urban medically underserved areas with three new sites per year of the grant

cycle; 2. increase partnership with families of CYE and improve the family professional partnership in shared-decision making for all aspects of care for CYE; 3.develop and implement a transition and transfer of care program for CYE to adult providers and services from pediatric primary care and specialty providers to adult primary care and specialty providers. ; 4. offer CYE with familial epilepsy access to genetic testing and genetic counseling; 5. Increase the number of youth and young adults with epilepsy who take responsibility for his/her health care needs; 6. increase family, public, and provider awareness of epilepsy through dissemination of existing guidelines and practice parameters for CYE; and implement the sustainability plan for beyond grant funding.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60.8	60.8	60.8	59.9	59.9
Annual Indicator	60.8	60.8	59.9	59.9	59.9
Numerator					
Denominator					
Data Source	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010	NS-CSHCN 2009/10	NS-CSHCN 2009-10
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	59.9	59.9	59.9	60	60

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
Children's Special Health Care Services (CSHCS) provides coverage for medical care and treatment for over 2,700
different diagnoses. In 2012, the program provided services to 35,431 children and some adults. Children's Special Health Care Services also has the Insurance Premium Payment Benefit. This benefit has been in place for over 17 years, whereby the state pays the private health insurance premium for the eligible client. This benefit allows for the CSHCS client to maintain their private health insurance coverage that they may otherwise not be able to afford. This enables the state to prevent a shift in the cost of medical services from the private health insurance company to CSHCS state funding. The majority of the premiums paid for the benefit are when COBRA coverage is offered to a family when the policyholder loses a job or a young adult is no longer a dependent. Cost effectiveness must be proven in order for CSHCS to pay premiums. In 2012, the Insurance Premium Payment Benefit assisted 251 families with insurance premiums, saving the program over 3.2 million dollars.
In 2012, CSHCS started enrolling beneficiaries into the Health Insurance Plan of Michigan - Michigan's High Risk Pool (HIP Michigan). The population identified as most cost effective for premium payment without an individual
determination consists of the following: age 18 and above who are covered by CSHCS for cystic fibrosis or four of
the five hemophilia codes who do not have any other type of insurance including Medicaid or Medicare. By paying the premiums for enrollment in HIP Michigan not only did CSHCS save state dollars by preventing medical costs being charged to state funds, but it would also provide a more comprehensive coverage for this population that would include primary care.

In 2011, a new CSHCS policy became effective requiring applicants who, based on financial information provided,
may be eligible for MIChild (Michigan's SCHIP program) or Medicaid to apply for the programs. As CSHCS only
provides payment for medical care and treatment of approved diagnoses, this change also increased access to
primary care and other services for many of our clients. Blue Cross Blue Shield (BCBS) was the participating MIChild insurance option with which children who were eligible for MIChild were enrolled. Beginning in the fall of 2013, BCBS will be phasing out of MIChild. MIChild enrollees will be transitioned to the Medicaid Health Plans to provide the MIChild benefits.

As of August 2012, Medicaid enrollees that are determined eligible for CSHCS will no longer need to complete the
CSHCS application process, and will be automatically enrolled in CSHCS effective in October. Additionally, CSHCS
clients that had been enrolled in Medicaid Fee-for-service have been transitioned into Medicaid

Health Plans (MHP).
There are some populations within CSHCS that are excluded or have the option but are not required to enroll.
CSHCS has worked with the MHPs, state partners, and providers for several months prior to the change to ensure a smooth transition. By enrolling eligible clients into MHPs, CSHCS clients will receive better access to primary care and increased care coordination.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented new CSHCS database for more efficient information sharing with local CSHSC offices.				X
2. Continued participation in the Michigan Local Public Health Accreditation Program.				X
3. Partnered with local public health to create six minimum program requirements for local CSHSC offices through the Michigan Local Public Health Accreditation program.				X
4. Completed site reviews of local public health departments as part of the accreditation process.				X
5. Provided training and outreach to community organizations.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2013, the HIP Michigan program became closed to new enrollees, but coverage was continued for those already enrolled. As of July 1st, CSHCS was required to stop enrolling beneficiaries into Michigan's High Risk Pool (HIP Michigan), and eligible clients were moved to a federal high risk pool.

The program continues to monitor the care of CSHCS clients in Medicaid Health Plans. CSHCS assists clients who
were enrolled in the HIP Michigan plan convert to the Federal ACA Plan until January 2014 when the full ACA
requirements become effective. CSHCS will provide further program outreach to publicize the program to enroll new clients with special health care needs. The program will plan to systematically share information about the CSHCS program and its benefits at identified entry points in partnership with the Family Center for CYSHCN. CSHCS will also continue to partner with the Family Center for CYSHCN by reaching out to Children's Hospitals, Pediatric Regional Centers, Children's Multidisciplinary Clinics and client organizations such as the United Cerebral Palsy Foundation, Hemophilia Foundation and others to provide training on accessing the program.

c. Plan for the Coming Year
To further ensure that CSHCS clients have adequate private and/or public insurance, CSHCS has developed tools
and partnered with external organizations to help eligible CSHCS clients enroll in the Healthy Michigan Plan
(Medicaid Expansion) or any of the available plans through the Health Insurance Exchange.

CSHCS has also
developed a work queue that allows our Local Health Department (LHD) affiliates to more readily identify CSHCS
clients that may be eligible for an insurance plan provided through the Health Insurance Exchange. This tool will be used by our LHD partners to provide outreach and education about the Health Insurance Exchange, as well as direct CSHCS clients to Certified Application Counselors.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90.9	90.9	90.9	71.7	71.7
Annual Indicator	90.9	90.9	71.7	71.7	71.7
Numerator					
Denominator					
Data Source	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010	NS-CSHCN 2009/10	NS-CSHCN 2009-10
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	71.7	71.7	71.7	72	72

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised

extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
Michigan relies heavily on our Local Health Department (LHD) partners to be the community based arm of the CSHCS program. CSHCS relies on the LHDs to assist families in locating additional resources within their community. Because CSHCS relies so heavily on the LHDs it is crucial that the division provides them with the most up to date information and streamlined process to handle client's needs. A new CSHCS database was implemented in March 2011. The database is now in use by all central office staff and our local health department partners and the technical issues that were experienced with the old system have been eliminated, making a more streamlined application, enrollment, and renewal process for all CSHCS clients and their families.

In 2011, the Division embarked on the process of participating in the Michigan Local Public Health Accreditation
Program for local CSHCS offices. A CSHCS workgroup worked closely with our public health partners to craft minimum program requirements for local CSHCS programs. As a result of the Accreditation workgroups six minimum program requirements were developed for local CSHCS programs.

• Minimum Program Requirement 1: The local health department (LHD) Children's Special Health Care Services
(CSHCS) program shall assure that adequate, trained personnel are available to provide outreach, enrollment and support services for children and youth with special health care needs (CYSHCN) and their families.
• Minimum Program Requirement 2: In accordance with the security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), the local health department CSHCS program shall manage CSHCS client protected health information (PHI) in a secure and private manner that results in coordinated care.
• Minimum Program Requirement 3: The local health department CSHCS program shall have family-centered policies, procedures and reporting in place.
• Minimum Program Requirement 4: The local health department CSHCS program shall provide outreach, case-
finding, program representation and referral services to CYSHCN/families in a family-centered manner and to
community providers.
• Minimum Program Requirement 5: The local health department CSHCS program shall assist families in the CSHCS application and renewal process as well as the application processes for other relevant programs.

• Minimum Program Requirement 6: The local health department CSHCS program shall provide information and
support services to CSHCS enrollees and their families. The division also worked closely with the Family Center for CYSHCN to provide outreach and information to 13 organizations regarding the CSHCS program, its benefits, and how to access services including the pediatric medical home model.

In March of 2012 an accreditation team from CSHCS began the first of the three year accreditation cycle site visits to local health departments. Sixteen local health departments completed the site reviews in 2012 and the remaining local health departments will have completed the accreditation process by 2014.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided medical care and treatment to 40,786 CSHCS beneficiaries.	X			
2. Assisted families in maintaining private health insurances by paying insurance premiums through the Insurance Premium Payment benefit.		X		
3. Partnered with Michigan's high risk pool, HIP Michigan, to enroll 220 qualified families.		X		
4. Required CSHCS applicants who may be eligible for Medicaid or SCHIP to apply for coverage.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A pilot project is currently being planned in partnership with Medicaid for a smart phone application available to
CSHCS enrollees. The smart phone mobile application will be called "Blue Button" and will provide the responsible
party of the CSHCS enrollee to access important information such as authorized provider's and local health
department contact information on their mobile device via a secure log-in. The pilot project intends to reach an
estimated 1000 CSHCS enrollees for test. Those who utilize and download the Blue Button application during this
pilot period will be asked to complete an in-application survey about their experience.

The CSHCS nurse consultant is working closely with local health departments to identify areas of need and to
provide technical assistance in many areas. The work has greatly strengthened the partnership between CSHCS
central office and the community based local health department staff. Currently the nurse consultant holds a
monthly conference call with the local public health nurses. The teleconference provides a great opportunity to share information and provide training on issues identified at the local level.
The CSHCS accreditation process was continued in 2013, and has completed 16 more site

reviews with local health departments. The goal for these accreditations remains to insure a high standard of services to our clients and their families.

c. Plan for the Coming Year

CSHCS will continue to work with our local health department partners in providing them with the most recent
information about the program and providing technical assistance with the use of Nurse Consultants. The CSHCS
Local Public Health Accreditation Program team has scheduled thirteen more site reviews through August 2014,
which will complete the first three year cycle of the accreditation process. The team will work with local CSHCS offices to coordinate the review process.

The division is working with our IT vendor partner to create a public interface for our CSHCS database. The plan for the coming year is to implement a secure web-based public interface to our database that will allow families to complete and submit the CSHCS application on-line.

Additionally, for the coming year the CSHCS program will continue to partner with the Family Center to provide
further outreach to the community with trainings and information distribution to hospitals and medical providers.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40.8	40.8	40.8	41.2	41.2
Annual Indicator	40.8	40.8	41.2	41.2	41.2
Numerator					
Denominator					
Data Source	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010	NS-CSHCN 2009-10	NS-CSHCN 2009-10
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	41.2	41.2	41.2	42	42

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The CSHCS division has worked to monitor closely the creation and distribution of transition anticipatory guidance
letters. Each month in 2012 the Medicaid System, CHAMPS, identified clients based on their birthdates to create five client/family specific letters for ages 16, 17, 18, and 21. Additionally, monthly, any CSHCS authorized provider with a client turning 16, 18, and 21 received a letter reminding them of the importance to discuss transition planning with their client at their next visit.

CSHCS has a strong history of working with parent partners to provide input and perspective into program planning and policy. In 2011, the division created an opportunity to contract with a youth consultant to provide young adult input and perspective into program planning and policy. The Youth Consultant has participated in division strategic planning, advisory meetings, and been trained on youth leadership skills. She also provides review and offers guidance to make division

materials and outreach activities more youth friendly. The youth consultant worked to update the Family Center's Youth Scholarship program materials and a plan for communicating the scholarships availability to other young people on CSHCS. In addition to these activities the CSHCS Transition Specialist and the Youth Consultant collaborated on a workshop that was presented at the 2012 Association of Maternal Child Health Conference titled "Partnering with Youth to Shape Policy and Program Development".

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided transition anticipatory guidance to 7,000 transition age CSHCS enrollees.		X		
2. Strengthened the responsibilities and resources of the youth consultant who focuses on program development and transition activities for youth.				X
3. Created an on-line health care transition training module		X		X
4. Created "Under-Insured Work Queue" that allows our Local Health Department affiliates to provide outreach and support for enrolling in the Health Insurance Marketplace.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

For 2012/2013 the job description and responsibilities of the youth consultant were updated to have a greater
impact on program development. Part of the updated responsibilities includes revitalizing the transition activities for youth, and developing a social media presence. The youth consultant is now responsible for monitoring an open Facebook page for youth with special health care needs, as well as developing a closed Facebook page. The youth consultant is also working with Family Center staff to develop the Family Center website to include a youth section.
The youth consultant is being connected with AMCHP and other national and local resources to optimize the value of work produced.

Additionally, CSHCS has developed and implemented a transition plan for young adults receiving private duty
nursing that are going to turn 21 years old. Once a young adult turns 21, Medicaid will no longer cover private duty nursing in the State of Michigan. These young adults must transition on to a Medicaid Waiver option in order to continue receiving private duty nursing through a state plan. In 2013, CSHCS has successfully transitioned twenty young adults onto a waiver program. CSHCS continues to refine the transition process, and adapt lessons learned to our broader transition planning and transfer of care activities.

c. Plan for the Coming Year

The CSHCS Division will continue to provide outreach and education to enrollees through the use of anticipatory
guidance letters. With the movement of the dual eligible CSHCS and Medicaid population into Medicaid Health Plans and the changes that are taking place with the Affordable Care Act, the

division will continue to review and revise all transition anticipatory guidance that is sent to clients. Any changes and updates needed to the material will be made.

With the assistance of the CSHCS Youth Consultant, the Division will work to reinvigorate youth advisory activities. The Division will use social networking to connect with young adults and provide them with information and education about transition along with opportunities to get involved in policy and decision making at the state level.

CSHCS will continue to aid in the transition of young adults receiving private duty nursing on to the Medicaid
Waivers. The division will identify areas of improvement for the transition planning and transfer of care for our
clients. As well as establish evaluation metrics to determine the effectiveness of CSHCS transition practices.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	86	75	76	79
Annual Indicator	74.9	74.0	79.9	78.1	74.8
Numerator	139832	136556	144280	134595	125186
Denominator	186692	184536	180576	172337	167311
Data Source	National Immunization	National Immunization Survey	National Immunization Survey (NIS)	2011 National Immunization Survey (NIS)	Coverage level from the Michigan Care Improvement
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	78	79	80	80	80

a. Last Year's Accomplishments

The coverage levels reported above include one dose of varicella (chickenpox) vaccine, (4:3:1:3:3:1). The most recent data is reported from the Michigan Care Improvement Registry (MCIR) which is a statewide immunization tracking system used by providers. Because it is a population based registry the 74% immunization level is an underestimate of the true vaccination rate but is a higher rate than the 72.2% reported by the National Immunization Survey results for 2012. The rates obtained from the MCIR have remained at 74% for the last 2 years. The Immunization program is concerned about the stagnated immunization coverage levels and has been working to implement additional outreach programs to education the public and providers on the importance of vaccination.

The most recent immunization rates for Michigan as measured from the National Immunization Survey (NIS) show Michigan at 70.5% which is a 4% increase from the prior year for the 4:3:1:3:3:1:4 series of vaccines. 4:3:1:3:3:1:4 represents; 4 DTaP, 3 polio, 1 MMR, 3 hib, 3 hepatitis B, 1 varicella, and 4 pnuemococcal conjugate vaccines. This data is obtained from 2012 National Immunization Survey data compiled by the CDC. When adding in 4 doses of pneumococcal vaccine to the rates from MCIR we are still at 74%. The 4313314 series better represents a complete immunization schedule for children.

From October 1, 2012 -- September 30, 2013 the Immunization Program ordered and distributed 1,894,673 doses of vaccine valued at over $84 million to local health departments and participating private providers.

In 2013 the Immunization Program enhanced the ability to receive HL7 messages from provider electronic medical record systems. By the end of 2013, 1,011 provider offices were successfully sending immunization data to the MCIR using HL7 messages through the State Data Hub and MIHIN. This new functionality in the MCIR and EMRs allows the data to be transmitted upon entry to the EMR and available within the MCIR almost immediately.

MCIR developed a flu vaccine pre-booking module which allows vaccine providers to forecast flu vaccine need for the upcoming influenza season. Over 1,000 providers utilized the module.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to work with appropriate staff to change the school requirement for reporting of 7th grade students for the 2014 school year.			X	
2. Create a two-way interface for providers to submit and receive vaccine information from the MCIR to the Electronic Medical Records system in provider offices.			X	X
3. Work with the Michigan Health Information Exchange to create a Master Person Index.			X	X
4. Pilot using 2-D scan technology to collect immunization data in			X	X

the MCIR.				
5. Improve management of the VFC program using the MCIR including an automated VFC enrollment system which has a better and more user friendly vaccine accountability system.			X	X
6. Continue work to develop an EDHI case management system within the MCIR.			X	
7. Work with local health departments and other partners to research barriers on the uptake of HPV and other routinely recommended adolescent vaccines.			X	
8. Continue to work with local health departments and other partners to track immunization levels statewide to identify pockets of need and identify areas with low immunization rates and high exemption rates.			X	
9.				
10.				

b. Current Activities

Enhancements are underway to improve the provider vaccine inventory interface. With increased emphasis on improved vaccine accountability by the CDC, the Division of Immunization is redeveloping the functionality within the MCIR to better track vaccine inventories and all transactions associated with the inventory.

The Division of Immunization is working to increase immunization levels for adolescent vaccines. In recent years there has been an increased emphasis on the newer recommendations for adolescent vaccines such as Tdap, Meningococcal, and HPV vaccines. Much progress has been made on increasing the uptake of Tdap and Meningococcal vaccines but HPV vaccination rates in Michigan remain low. MCIR will be utilized to increase notification activities in provider offices focused in SE Michigan of individuals who have not received all recommended vaccines. MCIR is also creating new functionality within the MCIR to allow providers to generate coverage levels reports for all adolescent vaccines.

Development has begun on a Perinatal Hepatitis B Case Management System built in the MCIR. This system will be used to manage all infants born to mothers who are surface antigen positive for Hepatitis B at the time of birth. This system will also have the ability to track all potential contacts as well.

The Immunization program will implement county level report cards showing a variety of immunization levels by county and how they rank compared to other counties in the state.

c. Plan for the Coming Year

On January 1, 2014 the Immunization Program will implement the changes to the Public Health code requiring the reporting of immunizations of all 7th grade students. This new implementation requires communication with all the school programs to inform them on the change and also make the needed changes to the MCIR system to accommodate the new reporting requirement. Better compliance could be accomplished by allowing providers to follow the nationally recommended schedule.

The Immunization program is working to develop a two way interface with Electronic Medical Record systems used in provider offices to the MCIR. This two way interface will allow providers to receive vaccine history information from the MCIR each time a child is accessed within the EMR. This interface will also provide the vaccine forecasting back to the provider office so the user will know due dates for any due or past due vaccines. The planned implementation date for the two way interface is September 2014.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17	16	15.9	12.4	11.6
Annual Indicator	15.5	14.4	12.7	11.9	10.4
Numerator	3354	2966	2583	2380	2092
Denominator	216619	205391	204172	200736	200736
Data Source	MI vital Records	MI Vital Records	MI Vital Records	MI Vital records	MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	10.3	10.2	10.1	10	10

a. Last Year's Accomplishments
MDCH aired its two youth-focused PSAs on TV and YouTube -- "Wish I Waited" and "Take It Back" as well as PSA's focusing on abstinence in several areas in Michigan for adolescents.

MAP, TPIP and TPPI grantees provided teen pregnancy prevention programming to youth and parents in their communities. MDCH provided training opportunities for program staff and facilitators, as well as ongoing technical assistance.

MAP hosted its annual MAP Training in June and TPIP hosted its bi-annual Institutes in November and June.

MDCH hosted the 6th Annual Moving Toward Solutions Conference on August 11-13, 2013 in Dearborn with approximately 250 participants from all across Michigan.

MDCH continued to work on the development of a Statewide Adolescent Sexual Health Plan.

MAP issued extension grants to 6 MAP grantees. Grantees were able to expand their programs into other areas and schools, reaching youth that otherwise would not have the benefit of abstinence education.

MAP evaluation plan and results were accepted as a poster presentation at the Michigan Premiere Public Health Conference.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided abstinence education to 3,288 youth through the Michigan Abstinence Program (MAP).		X		

2. Provided comprehensive sex education to 4,355 youth through the Taking Pride in Prevention (TPIP) and Teen Pregnancy Prevention Initiative (TPPI).		X		
3. Provided parent education to 2,110 parents through MAP, TPIP and TPPI.		X		
4. Supported local programs and advisory councils through MAP, TPIP and TPPI.				X
5. Conducted a statewide media campaign.			X	
6. Hosted the 6th Annual Moving Toward Solutions, which was attended by approximately 250 individuals throughout Michigan.				X
7. Hosted grantee trainings for all MAP, TPIP and TPPI grantees on program evaluation, content, reporting, etc.				X
8.				
9.				
10.				

b. Current Activities
MDCH airs its two youth-focused PSAs on TV and YouTube -- "Wish I Waited" and "Take It Back" as well as PSA's focusing on abstinence in several areas in Michigan for adolescents.

MDCH will host the 7th Annual Moving Toward Solutions Conference August 17-19, 2014 in Ypsilanti.

MDCH is working on finalizing its Statewide Adolescent Sexual Health Plan, in partnership with MDE and MOASH.

MAP will host its annual MAP Training in June in Traverse City. ETR will present on Program Sustainability and Engaging the Adolescent Brain. TPIP hosted its first Institute of the year in November, and the second will be in June.

MAP, TPIP and TPPI grantees provide teen pregnancy prevention programming to youth and parents in their communities. MDCH provides training opportunities for program staff/facilitators, as well as technical assistance. Funding for MAP, TPIP, and TPPI is available through FY 2015.

MDCH issued an expansion grant for all TPIP grantees. The purpose was to allow grantees the opportunity to expand their youth programming activities through the remainder of FY 14.

MAP is sponsoring the National Abstinence Education Association's Sexual Risk Avoidance Certification training for grantees in May 2014, which will certify all participants in Abstinence Education.

MDCH received Pregnancy Assistance Funds for MI-APPP to work with 5 funded grantees to provide case management and other support services for pregnant and parenting teens, as well as preventing/delaying repeat pregnancies.

c. Plan for the Coming Year
MDCH will host the 8th Annual Moving Toward Solutions Conference in August 2015.

MAP will host its annual MAP Training and TPIP will host its bi-annual Institutes in November and June.

MAP, TPIP and TPPI grantees will continue to provide teen pregnancy prevention programming to youth and parents in their communities. MDCH will provide training opportunities for program

staff and facilitators, as well as ongoing technical assistance. FY 15 will be the last year of funding for MAP, TPIP, and TPPI for the current grant cycle.

MAP plans to include implementing strategies to assist grantees in their efforts to increase parent engagement.

MAP, in partnership with MPHI, is researching the feasibility of conducting a longitudinal study involving MAP participants.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	40	26.5	27	29
Annual Indicator	26.0	26.4	27.0	28.7	29.8
Numerator	33579	34449	30242	32471	32860
Denominator	129152	130492	111985	113332	110437
Data Source	SEALS Data	Kids County & MDCH Data Warehouse	MDOE	MDOE & DCH Data Warehouse	MDOE & DCH Data Warehouse
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	30	32	34	35	35

Notes - 2011
The data for 2011 is more accurate. The MI Dept of Education supplied the OHP with the actual number of 3rd graders. With the claims utilization data also being definitive from Medicaid, Healthy Kids Dental and MIChild, the number of unduplicated 3rd grade children is more accurate. Queries have been developed by agencies so they can now run the requests annually. With that information, the percentage has increased. Beyond 2014 when the ACA is implemented, it is hard to project the estimates.

a. Last Year's Accomplishments
The Oral Health Program awarded new SEAL! Michigan school-based dental sealant program grants to nine grantees. The sealant coordinator was able to make site visits to all the grantees. The Annual technical workshop was held with training on establishing program evaluation of the

sealant programs. The Delta Dental Foundation provided another award of $1500,000 to the Oral Health Program to aid in the SEAL! Michigan program. The number of schools increased to over 225 for the sealant program. The SEAL of APPROVAL program was implemented with an initial three agencies signing a Memorandum of Agreement with the Oral Health Program. Sealant coordinator presented a poster at a national school nurse conference on the role of school nurses in the school-based dental sealant program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral Health Coalition.				X
2. Oral Health Burden Document.				X
3. State Oral Health Plan.				X
4. Healthy Kids Dental expansion.	X			
5. SEAL! Michigan dental sealant program expansion			X	
6. Infant Oral Health program and fluoride varnish program for non-dental providers .	X			
7. Education and training for WIC and MIHP providers.		X		
8. Community Water Fluoridation Equipment Grants.			X	
9. PA 161 Public Dental Prevention Program expansion.	X			X
10. Count Your Smiles Survey (BSS for 3rd graders).				

b. Current Activities

The sealant coordinator continues to monitor all the SEAL! Michigan grantees. The sealant coordinator is providing assistance to a pilot program with a school-linked health center in establishing a school-based dental sealant program. This pilot program is also targeting an ethnic and minority population on oral health issues. The sealant coordinator is also providing technical assistance to the Oral Health Workforce grant on two activities that include school-based dental sealant programs and mentoring high school students.

c. Plan for the Coming Year

The sealant coordinator will continue to provide technical assistance to the funded SEAL! Michigan grantees and the new SEAL of APPROVAL (SOAP) non-funded sealant programs. The sealant coordinator will continue to provide technical assistance through the Oral Health Workforce grant to a university using dental hygiene students to develop a school-based dental sealant program and provide assistance with mentoring high school students for learning about public health and school-based dental sealant programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	2.3	2.2	1.7	1.7	1.7
Annual Indicator	1.9	2.1	1.5	2.0	2.0
Numerator	36	40	29	37	37

Denominator	1945927	1909286	1878903	1854543	1854543
Data Source	MI Vital Records	MI Vital Records	MI Vital records	MI Vital Records	MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.9	1.8	1.7	1.6	1.5

Notes - 2012
Data are unavailable at this time due to technical issues with the Electronic Death Record system.

a. Last Year's Accomplishments
MDCH supports the Child Passenger Safety (CPS) network by assisting with local CPS efforts and providing assistance to child safety seat programs of its 13 community-based Safe Kids Coalitions as requested, and provides education through various media outlets.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support Safe Kids Coalition efforts to conduct child passenger safety checks.			X	
2. Develop educational messages for various media outlets on passenger, pedestrian, and bicycle safety.		X	X	
3. Support training opportunities for certified child passenger safety technicians.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Assist local CPS efforts and providing assistance to child safety seat programs of its 13 community-based Safe Kids Coalitions as requested. Information campaigns were developed through various media outlets to educate parents and caregivers. Provide support for CPS certified technician classes through marketing and outreach through various community partners

c. Plan for the Coming Year
Assist local CPS efforts and providing assistance to child safety seat programs the 13 community-based Safe
Kids Coalitions as requested. Engage in informational campaigns through various media outlets to provide injury prevention education in child passenger safety, pedestrian safety and bicycle

safety. Provide support for CPS certified technician classes through marketing and outreach through various community partners.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	18	19	20
Annual Indicator	18.5	17.8	18.4	14.4	17.7
Numerator	8302	5541	8539	6038	8142
Denominator	44879	31130	46409	41923	46002
Data Source	PNSS/Ped/NSS	PNSS/PedNSS	PNSS/PedNSS	MI-WIC	MI-WIC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	18	20	22	24	26

Notes - 2012
CDC discontinued their PNSS/PedNSS surveys. Data for 2012 is from the MI-WIC data system.

a. Last Year's Accomplishments
The WIC Division continued to lead the Breastfeeding (BF) Collaborative within the Department of Community Health (DCH). Its purpose is to develop relationships between Programs and Divisions so that we can identify sources of breastfeeding support across DCH and address areas of opportunity. The Division also worked within the Bureau to draft a Position Description for a Department of Community Health Breastfeeding Coordinator. This position will eventually take leadership for the Collaborative, working across divisions and seeking to establish community partnerships to give a stronger voice for breastfeeding.

WIC continued to work with the Michigan Council of Maternal & Child Health (MCMCH), the Michigan Breastfeeding Network and Michigan Medicaid in an effort to find ways to provide quality breast pumps for Medicaid clients. Another joint effort was with the Healthy Kids Healthy Michigan project to prepare legislative policy briefs that are breastfeeding supportive in child care settings. WIC continued to be in partnership with the Michigan Nutrition, Physical Activity and Obesity Prevention Program. WIC worked with the Healthy Weight and the Maternal Infant

Health Program (MIHP) to obtain a CDC grant for lactation training of the MIHP home health care providers across the state. WIC reported against two of the Governor's Dashboard measures, obesity prevention and infant mortality as they relate to breastfeeding.

Lactation Education Consultants (LEC) provided Building Bridges to Breastfeeding Duration at four different hospitals: William Beaumont Hospital -- Royal Oak, St. John Moross Hospital -- Detroit, Mid-Michigan Hospital and Medical Center Gratiot -- Alma and Spectrum Health United Hospital in Greenville. Approximately 350 people attended these trainings. State WIC provided Breastfeeding Basics Training for 180 Local Agency (LA) staff and 82 MIHP staff.

WIC Conference was attended by 800 people. Shannon Whaley presented Obesity Prevention Through Breastfeeding. She spoke about the research and the foundational role that breastfeeding has in preventing childhood obesity. By utilizing case studies, Doctor Jack Newman offered what to look for in breastfeeding problem areas and useful methods for resolving them. His presentations Breastfeeding Concerns: What to Do When Baby Doesn't Gain Weight and What to do when Baby Doesn't Latch drew record numbers of attendees as WIC staff continually look for ways to support our breastfeeding clients.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Developed position description for Community Health Breastfeeding Coordinator to work across divisions and establish community partnerships				X
2. Worked with MI Council for Maternal & Child Health, MI Breastfeeding Network and MI Medicaid to develop legislative briefs in support of breastfeeding in child care settings				X
3. Worked with Maternal Infant Health Program (MIHP) to obtain CDC grant for lactation training of MIHP home visiting providers				X
4. Provided lactation education at 4 hospitals				X
5. Provided Breastfeeding Basics training for local WIC agency and MIHP staff				X
6. Provided education/training at WIC Annual Conference on breastfeeding and childhood obesity				X
7.				
8.				
9.				
10.				

b. Current Activities

The WIC Division continues to recruit applicants with the right experience and skills for the Breastfeeding Coordinator position through various partners and networks.

The Division continues to offer Breastfeeding Basics Training to local agency WIC staff across the state. Those trainings are marketed to local physician offices (working in maternity and pediatric care), Early Head Start, Programs, MIHP, the Nurse-Family Partnership and others. This training helps with the assessment and long-term support of breastfeeding dyads.

We continue to work cooperatively with the Michigan Breastfeeding Network, MCMCH and Medicaid to seek new approaches to providing Medicaid women with appropriate, quality breast pumps.

The 2014 Michigan WIC Conference was held in April. Vanessa Annibali from the Los Angeles

WIC Program presented Duration Matters: the Value of Breastmilk Beyond One Year. This session reviewed current recommendations and research for extended lactation and explored the nutritional, physiological and immunological contributions that breastfeeding provides to the mother and infant over the long term. This same presenter also spoke to Exclusive Pumping: laying the Yellow Brick Road. This reviewed reasons mothers exclusively pump breastmilk, the history of the practice and emerging trends.

This year, Michigan WIC took the lead in organizing and applying for the USDA/MWR Breastfeeding Mentorship Grant which was approved.

c. Plan for the Coming Year

The WIC Division continues to concentrate on developing local agency staff and assisting them in promoting and supporting breastfeeding with their clientele and partner agencies in their community. The Division will offer Breastfeeding Basics Training in five locations across the state in FY 2015. Breastfeeding Coordinator Training and Milk Expression Training will be offered in March. WIC Conference is planned for the end of April and will include two or more breastfeeding education sessions. Michigan WIC will again take the lead for the USDA/MWR Breastfeeding Mentorship Grant. It is our goal to offer Building Bridges annually and provide other grant supported training for our local agency staff. As has become the tradition, targeted training is provided for the Breastfeeding Peer Counselors at least three times each FY plus they attend WIC Conference.

It is anticipated that the MDCH Breastfeeding Coordinator position will be filled and WIC will help with orientation and other support as possible. The WIC Division will continue in 2015 to partner with Michigan State University to provide Mother-to-Mother breastfeeding support in the form of home visits, support groups, and client education in the local WIC Clinics. Other ongoing, active partnerships supporting breastfeeding are with Medicaid, the MCMCH, the Michigan Breastfeeding Network, and the Healthy Kids, Healthy Michigan Coalition's (HKHM) Health Policy Action Team (HPAT).

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	97.3	98.5	98.5	96.8	97.1
Numerator	112464	111491	111491	107931	108752
Denominator	115576	113153	113153	111534	112017
Data Source	EHDI Database	EHDI Database	EHDI Database	EHDI Database	EHDI Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Michigan EHDI continues to have 100% of birth hospitals participating in newborn hearing screening. In 2012, 96% of babies were screened no later than 1 month of age. Of infants diagnosed with permanent hearing loss, 54.3% (n= 88/162) were diagnosed no later than 3 months of age in 2012. Enrollment into early intervention services was 62% (n=20/32). EHDI continues to have some difficulty obtaining documentation of early intervention services due to FERPA (Family Education Rights and Privacy Act).

EHDI continues to provide consultation to birth hospitals, including site visits and offering online training. Providers can view hearing results via the Michigan Care Improvement Registry (MCIR). EHDI continues to build a new data system; a new system will allow reporting of follow-up testing online and eventually submission through the electronic health system. Lastly, EHDI continues to receive referrals for the family support program, Guide By Your Side. This program links families of newly identified infants with hearing loss to other families in order to provide family support though the initial stages of diagnosis to intervention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Achieve 100% participation of birthing hospitals.				X
2. Screened 10,8752.	X			
3. Provided training, technical assistance, and educational presentations.		X		X
4. Provided family support.		X		
5. Referred infants identified with hearing loss to Part C for early intervention services.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

EHDI continues to develop the new EHDI system with the MCIR program. Maintenance of the follow-up with system within Perkin Elmer continues along with development of a Guide By Your Side online system within Filenet. EHDI is also initiating learning collaborative teams to utilize quality improvement strategies to reduce lost to follow up rates.

c. Plan for the Coming Year

EHDI will collaborate with MCIR staff to develop a lost to follow up system to ensure tracking and surveillance of infants through screening, diagnostic, and intervention services. The program will continue providing hospitals with quarterly reports on screening efforts. EHDI materials will continue to be distributed for family and provider use. EHDI staff will make efforts to work closer with primary care providers to ensure follow-up care. THe EHDI program will hold advisory meetings and obtain provider/family input into the programs operations and activities. EHDI will create a statewide and two local collaborative teams to utilize Plan, Do, Study, Act (PDSA)

approaches to test small steps of change in regions of the state. These include development of a Regional Audiology Consultant contractual position, partnering with Wayne Children's Healthcare Access Program, collaborating with midwives regarding out of hospital births, and data sharing with Early On, Michigan's Part C program.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	6	4.6	4.1	4
Annual Indicator	4.7	4.6	4.1	4.1	4.0
Numerator	110445	107827	95103	94128	74182
Denominator	2349892	2344068	2331475	2295812	1854543
Data Source	2008 CPS	2009 ACS	2010 ACS	2011 ACS	2012 ACS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	3.9	3.8	3.7	3.6	3.5

a. Last Year's Accomplishments
According to the American Community Survey, the uninsured rate for children under 18 in Michigan was 4.0 in 2012, a slight decline from the previous year. The majority of uninsured children are between the ages of 6 and 17. Counties with the highest number of uninsured children under age 18 are in the Detroit-Metro area -- Wayne County (including Detroit), Oakland County and Macomb County. Counties with the highest percentage of their children under 18 uninsured are Midland, Lenawee, Eaton and Van Buren.

Employer-sponsored insurance is still the predominant source of coverage, although the percent of people (non-elderly) covered has decreased by 15.6% from 2001 to 2011. At the same time, the percent of people covered by public sources has increased by almost 69%.

From December 2012 to December 2013, the average monthly number of Medicaid recipients under age 18 decreased by 2.3%. Eligibility levels for Medicaid services to children ages 1-19 and the state's- CHIP program, MIChild, were maintained at 150% and 200%, respectively. MICHILD

Local health departments and other community agencies continued to carry out outreach activities, with consultation and technical assistance from the Michigan Department of Community Health.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue consultation and technical assistance to local health departments and other agencies for outreach activities				X
2. Maintain eligibility levels for Medicaid and MIChild (SCHIP)				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Department's outreach activities have focused on the expansion of Medicaid coverage for adults 19-64 years of age which became effective April 1, 2014. Strategies designed to reach uninsured parents can also identify eligible children not enrolled in existing coverage programs.

Insurance under the Affordable Care Act is available in Michigan through the federal exchange. Health insurance agents, navigators and certified application counselors provide assistance to consumers seeking coverage through the marketplace. Four entities in Michigan have been approved to run Navigator programs: American Indian Health and Family Services of Southeast Michigan, Inc., Arab Community Center for Economic and Social Services, Community Bridges Management Inc., and Michigan Consumers for Healthcare. These entities contract with local health departments, hospitals, community centers and other non-profit agencies to provide in-person assistance to consumers throughout the state.

c. Plan for the Coming Year
Continue outreach and assistance to consumers through local health departments and other local agencies.

Continue Department public information campaign to educate and enroll eligible applicants into the Healthy Michigan Plan (expanded Medicaid).

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	29	28.5	29	29.5	29
Annual Indicator	30.3	29.6	29.9	29.2	30.9
Numerator	34690	31382	34686	36647	33866
Denominator	114489	106019	116006	125632	109600
Data Source	PNSS/Ped/NSS	PNSS/PedNSS	PNSS/PedNSS	MI-WIC	MI-WIC
Check this box if you					

cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	28	27	26	25	24

Notes - 2012
CDC discontinued their PNSS/PedNSS survey. Data reported for 2012 is from the MI-WIC data system.

a. Last Year's Accomplishments
Childhood obesity was addressed in several presentations at the 2013 Michigan WIC Conference, attended by statewide WIC staff. Sessions included: Obesity Prevention for a Healthy Future and Pediatric Obesity: Identification and Intervention (Dr. Susan Woolford, Univ of MI), Obesity Prevention through Breastfeeding (Shannon Whaley), WIC's Role Within the Breastfeeding Landscape: Both on and Off Line (Ryan Comfort) and Keep Them Coming Back for More: Client-Centered Communications (Bernadette Landers). National USDA webinars on evidence-based program and outcome data were promoted.
WIC clients were supported in nutrition and lifestyle change through access to 22 online interactive education modules in English and Spanish and 67% of WIC clients, especially young millennia, utilized these. State and local agency developed behavior-staged client self-directed education (SDE) modules promoting activity and healthy eating behaviors that were posted on both Michigan and national WIC web sites.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Held special sessions regarding childhood obesity at WIC Annual Conference				X
2. Provided online education on nutrition and lifestyle change in English and Spanish				X
3. Developed behavior-staged client self-directed education modules promoting activity and healthy eating				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WIC Program continues to provide breastfeeding promotion and support as an initial approach to successful obesity prevention. Anthropometric measurements of all WIC children age 2-5 are routinely obtained and shared with WIC clients/parents/caregivers. Staff trainings (Anthropometrics, CPA, and Advanced CPA) continue to include focus on effective client-centered approaches, client engagement and self-empowerment and include USDA evidence-based nutrition messages shown to impact positive client lifestyle change around obesity. All children at BMI >85% are considered high risk and offered individualized care planning with the Registered Dietitian. A client SDE take-home video lesson with the (Tips for Healthy Kids) was completed and will be distributed to all WIC agencies in 2014. A general block session on "Progress and Next Steps on the War against Childhood Obesity" was presented by Elizabeth Kuhl, PhD, Wayne State University and grant recipient, at the State WIC annual conference (April 2014). WIC local agencies developed annual Nutrition Services Plans based on predominant client risks, with 11 of 47 agencies specifically targeting childhood obesity.

c. Plan for the Coming Year

Michigan WIC will continue to support initiation of breastfeeding and exclusive breastfeeding to prevent obesity, offer client learning opportunities and expand quality training opportunities for staff around the topics of breastfeeding, obesity prevention and intervention, and client-centered nutrition counseling. Revised training on WIC service delivery and coordination of care for WIC high risk clients is targeted for FY 2015.

Michigan WIC continues to collaborate with the Michigan State Nutrition Action Committee (MiSNAC), the Michigan Breastfeeding Network, the Capitol Area BF Coalition and members of the DCH BF Collaborative Workgroup. Information shared on state-wide initiatives, programs and activities is communicated in various ways to promote local agency consortiums and leverage nutrition education efforts.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16.8	16.7	15.2	15.1	15.1
Annual Indicator	17.8	15.2	16.5	14.9	14.9
Numerator	20087	17244	18271	16311	16311
Denominator	112805	113446	110458	109531	109531
Data Source	PRAMS	PRAMS	PRAMS 2010	PRAMS 2011	State Estimate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	14.8	14.7	14.6	14.5	14.4

Notes - 2013
CDC PRAMS has not provided the PRAMS 2012 Birth Cohort data set to Michigan at this date, so we have used 2011 data as provisional estimate.

Notes - 2011
Data collection is ongoing for 2011 PRAMS. Estimates were not generated due to recent changes in state smoking policies, the fluctuations in PRAMS estimates due to sample size, and the lack of data for prior year.

a. Last Year's Accomplishments
Michigan has addressed prenatal smoking cessation as a part of perinatal health and overall general population smoking cessation efforts. The Smoke free for Baby and Me (SFBM) is a provider training program based on providers assessing and counseling prenatal smokers.

FY 2012-2013 there were 652 individual who viewed the online course and 427 who were given a certificate of completion.

All providers in the Maternal Infant Health Program are required to take the SFBM and to utilize the information in their interventions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide certificate of completion of the SFBM online course.			X	
2. Review to Update SFBM online course.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Discussion with MPHI staff to discuss what will be needed to accomplish this project. Viewed MPHI's Power point presentation on their capacity to enhance and make the course more interactive and user friendly. We Plan for time, funding and staff availability prior to starting the work. And once all the elements necessary to start the project are available, experts from the tobacco section will be invited to review and comment on the draft.

c. Plan for the Coming Year
Plan for the update of the online course will depend on the availability of additional funds to support this revision. Actual work on the project will ensue with ongoing review of the project until completion.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2009	2010	2011	2012	2013

Performance Data					
Annual Performance Objective	7.3	7.3	7.2	7.2	7.2
Annual Indicator	7.8	9.9	6.6	10.2	10.2
Numerator	58	73	49	71	71
Denominator	739588	739599	739599	697010	697010
Data Source	MI Vital Records	MI Vital Records	MI Vital records	MI Vital Records	MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	10	9.5	9.2	9	8.5

Notes - 2012
Data are unavailable at this time due to technical issues with the Electronic Death Record system.

a. Last Year's Accomplishments
Staff continued to provide ongoing technical assistance to local and regional suicide prevention efforts as requested and as resources were available. They also continued to work with the Michigan Association for Suicide Prevention on implementation of the state suicide prevention plan.

Implementation of the Michigan Model was ongoing.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued implementation of the Michigan Model for Comprehensive School Health.			X	
2. Implementation of the state suicide prevention plan.				X
3. Technical assistance to local and regional suicide prevention efforts.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Staff are continuing to provide ongoing technical assistance to local and regional suicide prevention efforts as requested and as resources are available. They continue to work with the Michigan Association for Suicide Prevention on implementation of the state plan and are currently working with MASP on updating the plan. Staff are also working on an proposal for submission in response to the latest funding State/Tribal Youth Suicide Prevention Cooperative Agreement

request for applications from SAMHSA.

Implementation of the Michigan Model is ongoing.

c. Plan for the Coming Year
If a SAMHSA Youth Suicide Prevention Cooperative Agreement is received, the MDCH Injury & Violence Prevention Section will reactivate its formal youth suicide prevention program. Under the proposed plan, the program will involve three components: (1) systems change at both the state and local levels; (2) statewide training and technical assistance; and (3) public health surveillance of suicide deaths and suicidal behaviors among 10-24 year olds in the state.

Implementation of the Michigan Model will be ongoing, as will the availability of technical assistance to local efforts, regardless of whether or not federal funding is received.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	82	85	89
Annual Indicator	85.2	85.2	83.4	86.8	86.2
Numerator	1646	1617	1523	1540	1580
Denominator	1931	1897	1827	1775	1832
Data Source	MI Vital Records	MI Vital Records	MI Vital Records	MI Vital Records	MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	90	90	90	91	92

a. Last Year's Accomplishments
The first strategy in Michigan's Infant Mortality Reduction Plan, released 8/1/12, is to implement a regional perinatal system. Research indicates that ensuring that high-risk pregnant women and newborns receive risk appropriate care can reduce infant mortality and morbidity. The measure of the percent of VLBW infants delivered at facilities for high risk deliveries and neonates is relatively unchanged over the past five years. As the perinatal system of care is implemented, this measure can improve.

In 2013, work on the planning of the statewide perinatal coordinated system continued. In May 2013, the state endorsed national perinatal level of care guidelines (which were released in September 2012). The Certificate of Need (CON) NICU Bed Standards was reviewed. A workgroup convened to create language in the standards for Level II special care nursery beds.

The state convened a NICU follow-up committee. Three workgroups under this committee met and made recommendations in 2013. One workgroup looked at risk assessment criteria an infant in the NICU would meet in order to have a NICU follow-up pre-discharge and post discharge home visit. Infant, maternal and family psycho-social risk criteria were recommended. The second workgroup looked at the development of a statewide developmental assessment program with recommendations for core elements. The last workgroup looked at how to increase enrollment in two state programs (CSHCS and Maternal Infant Health Program) at the time of delivery/birth.

The state continues to have several regional projects. The first is the Michigan Collaborative Quality Initiative (MICQI) that works in collaboration with the Vermont Oxford Network. The MICQI is working on quality projects to decrease central line infection in the NICU, increase breastmilk use in the NICU and to learn new ways to help drug addicted infants and their families. The second project is a NICU follow up project on the west side of the state. The project consists of two components: an enhanced multidisciplinary developmental assessment clinic and a home visitation component. NICU pre and post-discharge home visits were made to eligible families by CSHCS nurses. The Northern Michigan Perinatal Integration Model of Care project is a leadership team which has identified access to care, home visitation and a 21 county FIMR as key strategies as they build a collaborative team that is implementing a regional perinatal system. , A telemedicine project was implemented in a northern community that had no access to high risk prenatal care. This project serves as a model for other rural areas of the state that do not have maternal fetal specialists available in their communities.

Michigan was one of four states to be selected in the 1st cohort of National Governors Association Learning Network. In April 2013, a meeting with stakeholders across the state met to discuss strategies for reducing infant mortality in Michigan, which included breakout sessions on Perinatal Regionalization and the health of women and girls. Both strategies are important in reducing very low birth weight infants. The state also participates in Region V federal Collaborative Improvement and Innovation Network (COIIN).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor data of low birth weight infants delivered at high-risk facilities to assure system of referral is working.				X
2. Determine communities with racial disparities in infant mortality have significant percentages of VLBW infants born in hospitals without a NICU.				X
3. Continue the development of a statewide perinatal coordinated system.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CON Standards for Neonatal Intensive Care Services/Beds and Special Newborn Nursing Services went into effect on March 3, 2014. The addition of special newborn nursing services for the first time ever marks a new era of quality and safety for newborn care in the state.

The state is looking at Back Transports, payment/reimbursement issues for perinatal services and

convening two more workgroups to work on NICU home visitation components and linking infants to a Medical Home and community integration.

Year one process evaluation of the perinatal care system is in development.

A second nurse consultant was hired to continue the perinatal care system development and implementation.

c. Plan for the Coming Year
A key strategy to assure VLBW infants are delivered at facilities equipped to care for them is to implement the perinatal system of care and to have a surveillance system in place to monitor this trend.

The implementation of the CON NICU/SCN beds standards will facilitate the process. Additional work on interfacility transport, back transports, assuring high risk women are receiving the speciality care they need during the prenatal care.

Data from FIMR teams and from PPOR analysis by regional areas continue to be essential data to develop strategies to reach women who have a history of no prenatal care or high-risk pregnancies. Fiscal resources remain a challenge.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90.3	90.3	75	75	75
Annual Indicator	73.5	74.3	74.6	74.3	73.2
Numerator	85762	85269	85141	83766	82389
Denominator	116610	114717	114159	112708	112503
Data Source	MI Vital Records	MI Vital Records	MI Vital records	MI Vital Records	MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	76	80	82	85	85

a. Last Year's Accomplishments
Women report a variety of barriers to accessing prenatal care, according to PRAMS) including they couldn't get an appointment, provider or health plan wouldn't start, didn't have enough money, didn't have a Medicaid card, didn't have transportation or child care. Local health departments continue to have Medicaid Outreach to assist women to get Medicaid and into care. Once women are in care, there are a number of home visitation programs in place which provide

services that complement prenatal care (i.e. Maternal Infant Health Program (MIHP) and Nurse Family Partnership (NFP)).

One of the governor's priorities in his campaign to reinvent Michigan is to reinvent our health care system. The establishment of the structure and processes involved in a statewide perinatal coordinated system are under development which will facilitate entry into prenatal care earlier.

Michigan has submitted the final Blueprint for Health Innovation to the Center for Medicare and Medicaid Innovation. The Blueprint is Michigan's final product of the State Innovation Model planning process which has occurred over the course of the last year. The Blueprint provides a framework for moving forward into the next phase: preparing the State Innovation Model test grant application. The grant application will propose regional pilots to test new models of care and new ways to pay for it to achieve the triple aim of improved population health, improved consumer experience of care and reduced cost.

Michigan received CMS funding to support a 3-year multi-payer demonstration project that began in January 2012. Michigan's Patient-Centered Medical Home (PCMH) demonstration is the largest in the nation. PCMH involves a team-based model of primary care that provides continuous, coordinated whole-person care throughout the patient's lifetime to maximize health outcomes.

The Medicaid Family Planning Waiver continued with outreach and assistance for FQHCs and other providers.

The state's evidenced based home visitation program-Maternal Infant Health Program (MIHP) assisted over 40,000 pregnant women, with Medicaid insurance, with accessing prenatal care. The articles published regarding the effectiveness of MIHP show that MIHP improves maternal prenatal and postnatal care and infant care and reduces the risk for adverse birth outcomes (prematurity, extreme prematurity, low birth weight, very low birth weight) with particular advantage for African American women. (1. Cristian Meghea, PhD, Institute for Health Policy and Department of Obstetrics, Gynecology, and Reproductive Biology (Medicaid Home Visitation and Maternal and Infant Healthcare Utilization American Journal of Preventive Medicine, Volume 45, Issue 4, Pages 441-447, October 2013.) 2.Cristian Meghea, PhD, Institute for Health Policy and Department of Obstetrics, Gynecology, and Reproductive Biology and Lee Anne Roman, MSN, PhD, Department of Obstetrics, Gynecology, and Reproductive Biology Michigan State University, College of Human Medicine (A Statewide Medical Enhanced Prenatal Care Program: Impact on Birth Outcomes. JAMA Pediatrics, 2013. In print).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with multiple referral pathways through women & family programs to promote access & encourage early prenatal care being in the first trimester: LHD, PCMH, MIHP, WIC, Plan First, MOMS,NFP, Healthy Kids for Pregnant Women.				X
2. Community linkages that emphasize connection and referral to primary care providers, local health department, family planning clinics, and federally qualified health centers (FQHCS).				X
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The statewide perinatal care system is under development. System components are being defined and coordinated with other systems. Prenatal care is an essential component of the system.

The department is working with the MI Primary Care Association to bring Centering Pregnancy/Parenting to up to four FQHCs. Planning for this effort will be underway in 2014.

MIHP continues its efforts to assure women with Medicaid insurance access prenatal care early including assessment of needs at intake, utilization of standardized plan of care to address prenatal care access concerns and care coordination services to assure women follow through. MIHP discharge summaries include a data field that notes whether the participant accessed care prior to 14 weeks.

c. Plan for the Coming Year
The Perinatal Care System will continue to evolve. The system will integrate with other systems such as the medical home project and community integration. Continuation of the PCMH involving a team-based model of primary care that provides continuous, coordinated whole-person care throughout the patient's lifetime to maximize health outcomes, and requires improved access.

Development of regional pilot test sites for the State Innovation model if the grant application is accepted.

MIHP will continue to assist pregnant women with Medicaid insurance with accessing early prenatal care and will document when participants actually received care. Additional articles will be published regarding the effectiveness of this evidence based program and will include information about the effect of early entry into MIHP and dosage (number of home visits).

D. State Performance Measures

State Performance Measure 1: *Percent of pregnancies that are intended*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			54.7	54.7	56
Annual Indicator	55.4	54.8	55.5	58.2	58.2
Numerator	62563	62168	61007	63507	63507
Denominator	112855	113446	109961	109026	109026
Data Source	PRAMS	PRAMS	PRAMS 2010	PRAMS 2011	State Estimate
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	57	60	62	65	65

Notes - 2011
Data collection is on-going for 2011 births using the PRAMS survey. Given the recent reduction in population of women of reproductive age in Michigan, we chose not to estimate this figure using vital records data.

2010 remains provisional as the PRAMS data are still being weighted by CDC and the final file has not been provided to Michigan.

a. Last Year's Accomplishments
Funding for Michigan's Title X Family Planning includes Title X Federal grant, state appropriation, and other Federal sources. Due to ongoing reductions in state funding, The Michigan budget for FY 2013-14 has continued to reduce funding for family planning services. The state appropriation for local program allocations was reduced to $112,250 for FY 2013-2014. Family Planning delegate agencies also face cuts in local funding as communities and businesses struggle to survive in the current economic environment. Local agencies have scaled back their family planning programs by closing clinics, reducing hours, and/or reducing staff.

MIHP, through Medicaid policy, required that family planning be discussed at every visit during pregnancy. Referral to family planning services was an integral part of the standardized MIHP service delivery model, as was discussion of interconception care. Data regarding "intent to be pregnant " was collected during completion of the Maternal Risk Identifier (MRI) and standardized Plans of Care(POC) were utilized to address specific reproductive health risks. Family planning "plan in place" and "method identified" was gathered on discharge summaries that were linked to the MRI were then entered into the State data base.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided Family Planning services statewide.		X		
2. MIHP programs will assess pregnant and postpartum women for family planning needs using evidence based risk identifiers (140 programs).	X			
3. Risk Identifiers will be entered into the State of Michigan Single Sign On (SSO) data base (approximately 55,000 per year).			X	
4. Reports on intent to use family planning and family planning utilization will be pulled when the IT system has the capability.			X	
5. Individual MIHP programs will provide family planning care coordination services with fidelity to model (standardized Plans of Care).		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Michigan's Title X family planning delegate agencies provided services to 17,741 teens which included 17,419 females and 322 males. Currently 19.4% of the caseload is teens (17,741 of 91,588 clients)

The Michigan Department of Community Health (MDCH)/Medical Services Administration withdrew a State Plan Amendment (SPA) for family planning services to the Centers of Medicare

and Medicaid Services and expanded their Section 115 Family Planning Waiver until June 30, 2014. Also the State's Legislature approved of the State's Medicaid Program which began enrollment April 1, 2014.

MIHP through its 140 agencies continues to provide standardized assessment and intervention around family planning risks/needs and refers all pregnant and postpartum to a reproductive health provider, if they are willing. Guidelines regarding "how to talk about family planning" were developed and distributed throughout the state. The guidelines are available on the MIHP website www.michigan.gov/mihp.

c. Plan for the Coming Year
MDCH/Family Planning Program continues to make available general reproductive health assessment, comprehensive contraceptive services, related health education and counseling, and referrals as needed to every citizen of the state.

MIHP will continue to provide standardized assessment and intervention around family planning risks/needs and refers all pregnant and postpartum to a reproductive health provider, if they are willing. Data regarding intent, plan and method will continue to be collected and added to the SSO data base. MIHP is also exploring developing a family planning methods training for MIHP providers in collaboration with State family planning staff.

State Performance Measure 2: *Percent of low birthweight births (<2500 grams) among live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.9	7.8	7.8	8.4	8.3
Annual Indicator	8.4	8.4	8.4	8.5	8.3
Numerator	9846	9685	9576	9535	9284
Denominator	117309	114717	114159	112708	112503
Data Source	MI Vital Records	MI Vital Records	MI Vital Records	MI Vital Records	MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	8.2	8.1	8	7.8	7.7

a. Last Year's Accomplishments
Low birth weight (LBW) is a leading cause of infant mortality in Michigan. There are many causes to low birth weight which include congenital anomalies, prematurity, placental problems and maternal infections, multiples, previous low birth weight infants, poor nutrition, smoking, substance use and abuse, alcohol abuse, lead exposure and insufficient prenatal care. According to the March of Dimes, the rate of infants born LBW in MI increased nearly 4%. Infant born at LBW are more likely to experience long-range physical and developmental health problems.

For the second year, the department funded an educational webinar series to birth hospitals that have a problem with neonatal abstinence syndrome (NAS). There were 28 hospitals participating in 2013. Each participating hospital identified a quality improvement project working with substance exposed families.

The Fetal Alcohol Spectrum Disorders program continues to provide prevention, awareness and access to services through Centers of Excellence. The Prenatal Smoking Cessation Program is designed to work with pregnant smokers who are receiving health services in prenatal programs.

The fetal-infant mortality review program identifies and analyzes factors that contribute to fetal/infant death. These factors are considered during the planning of interventions which can help to reduce LBW infants.

Practices to Reduce Infant Mortality through Equity (PRIME) continues its work to reduce racial disparities in infant mortality between Blacks/Whites and between American Indians/Whites in Michigan. The Michigan Health Equity Status Report -- Focus on Maternal and Child Health released in 2013 gives further insight in to the state of inequity in Michigan as of 2010. Policies for access to care across the lifespan, with a health equity lens, are needed to reduce low birth weight disparities.

The statewide perinatal care system is under development. In 2013 there were workgroups that made recommendations regarding a statewide developmental assessment program and a NICU risk assessment program to refer families to a pre and post-discharge home visit.

The state is working to reduce elective deliveries prior to 39 weeks. All birth hospitals provided an attestation agreement to MI Medicaid that they had policies in place to prevent elective deliveries. The Michigan Health and Hospital Association's (MHA) Keystone OB initiative worked with hospitals to implement the 39 week initiative.

Collaborative Improvement and Innovation Network (CoIIN) was expanded to Public Health Region V in 2013. Region V priority strategy areas include: improve preconception and interconception care, prevent SIDS/SUID, address social determinates of health and reduce elective deliveries before 39 weeks gestation.

Michigan was one of four states to be selected in the 1st cohort of National Governors Association Learning Network. In April 2013, a meeting with stakeholders across the state met to discuss strategies for reducing infant mortality in Michigan, which included breakout sessions on Perinatal Regionalization and the health of women and girls. Both strategies are important in reducing low birth weight infants.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide smoking cessation services and supported tobacco quitline.		X		
2. Continued MIHP program that targets high-risk pregnant women and infants.		X		
3. Continued MIHP collaboration with WIC to identify clients and improve nutrition and weight gain.		X		
4. Continue to address the disparity in African American low birth weight rates in Michigan.				X
5. Nurse Family Partnership program continues to enroll and serve low income, first-time pregnant women.	X			
6. Implement a statewide perinatal care system.				X
7.				
8.				
9.				
10.				

b. Current Activities
The Healthy Michigan Plan was implemented in April 2014. This will allow more families access to health care, including preconception care. Women who are healthy going into a pregnancy have healthier babies.

The NAS webinar series continues in 2014. There are 25 participating hospitals. All hospitals work on a quality improvement process related to NAS.

The statewide perinatal care system is under development. System components are being defined and coordinated with other systems.

c. Plan for the Coming Year
Further development of the perinatal care system will occur. Additional workgroups will be formed to identify the pre and post discharge NICU home visitation and link to Medical home.

MHA is working on two new initiatives for Keystone OB: postpartum hemorrhage and reduction of primary cesarean sections.

Work to improve preconception and interconception care.

State Performance Measure 3: *Percent of preterm births (<37 weeks gestation) among live births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10.2	10.1	10.1	9.5	12
Annual Indicator	9.8	9.8	12.3	12.2	12.0
Numerator	11542	11205	14041	13798	13541
Denominator	117309	114717	114159	112708	112503
Data Source	MI Vital Records	MI Vital Records	MI Vital records	MI Vital Records	MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	11.5	11	10.5	10	9

a. Last Year's Accomplishments
According to the March of Dimes, MI preterm birth rate increased nearly 2% between 2001 and 2011. Since 2011, the preterm birth rate has decreased slightly. Approximately three-quarters of all preterm births occur spontaneously and the remainder result from medical intervention. The most consistently identified risk factors for spontaneous preterm births include a history of preterm birth, current multifetal pregnancy and some uterine and/or cervical abnormalities. Babies born before 37 completed weeks of gestation are at increased risk of immediate life-threating health problems as well as long-term complications and developmental delays. Prematurity and low birth weights remain the leading cause of infant death in Michigan. The infant mortality rate among premature infants is 17 times higher than normal gestation. There continues to be a racial disparity among premature infant deaths with black infants significantly higher compared to

Hispanic and white infants.
Michigan accepted the March of Dimes and Association of State and Territorial Health Officials pledge of an 8% reduction in preterm birth rate by 2014.
Michigan was one of four states to be selected in the 1st cohort of National Governors Association Learning Network. In April 2013, a meeting with stakeholders across the state met to discuss strategies for reducing infant mortality in Michigan, which included breakout sessions on Perinatal Regionalization and the health of women and girls. Both strategies are important in reducing preterm births.
The state is working to reduce elective deliveries prior to 39 weeks. All birth hospitals provided an attestation agreement to MI Medicaid that they had policies in place to prevent elective deliveries. The Michigan Health and Hospital Association's (MHA) Keystone OB initiative worked with hospitals to implement the 39 week initiative. Some of the late preterm births born between 34-36 weeks' gestation may be linked to practice-based efforts to reduce elective deliveries prior to 39 weeks. The Maternal Infant Health Program (MIHP) presented on the importance of this effort in the semi-annual MIHP Coordinator's meeting and has formally adjusted the standardized Plan of Care to remind the 140 agencies and approximately 3000 staff of the initiative.

Other population strategies in Michigan to reduce preterm births include alcohol prevention strategies through the Fetal Alcohol Syndrome Disorder (FASD) program, Smoking Cessation program which supports a tobacco Quitline to help women reduce or stop smoking during pregnancy, continuation of Section 1115 Family Planning Waiver to reduce unintended pregnancies, and home visitation programs to support women during pregnancy and complement provider prenatal care visits such as through the nine Nurse Family Partnership programs (NFP) and through over 140 agencies that participate Maternal Infant Health Program (MIHP), a benefit for all Medicaid pregnant women and their infants .
The Fetal and Infant Mortality Review (FIMR) program continued in 12 communities in Michigan, providing an important source of data to describe significant social, economic, cultural, safety, health and systems factors that contribute to infant mortality and preterm, and to design and implement community-based action plans founded on the information obtained from the reviews.

Michigan's Infant Mortality Reduction Plan, released in August of 2012, has identified several strategies that will help reduce preterm births: implement a regional perinatal system; promote the adoption of policies to eliminate medically unnecessary deliveries before 39 weeks gestation; promote adoption of progesterone protocol for high-risk medically eligible women; expand home-visiting programs to support vulnerable women and infants; support better health status of women and girls; reduce unintended pregnancies; weave the social determinants of health into all targeted strategies to reduce racial and ethnic disparities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue the MIHP program that serves all pregnant women who have Medicaid insurance.	X			
2. Implement a statewide perinatal care system.		X		
3. Continue and expand Nurse Family Partnership programs for education on preterm birth, social and medical support to reduce preterm births.		X		
4. Continue to analyze statewide FIMR data and inform programs on characteristics associated with premature births.				X
5. Continue to implement the MDCH Infant Mortality Strategic priority strategies; reduce elective births < 39 weeks gestation.				X
6. Continue to promote population prevention program strategies such as elimination of alcohol and smoking.			X	

7.				
8.				
9.				
10.				

b. Current Activities
The statewide perinatal care system is under development. Prenatal care, birthing hospitals, linkage to community health resources & addressing the social determinants of health are essential components of the system. The Certificate of Need Standards for NICU Services/Beds & Special Newborn Nursing Services went into effect on March 3, 2014. The addition of special newborn nursing services for the 1st time ever marks a new era of quality & safety for newborn care in the state.

MIHP program is growing! Research regarding the effectiveness of MIHP has been published. The articles show that MIHP improves maternal, prenatal & postnatal care & infant care & reduces the risk for adverse birth outcomes (prematurity, extreme prematurity, LBW, VLBW) with particular advantage for African American women. [1. Meghea, C. (2013) Medicaid Home Visitation & Maternal and Infant Healthcare Utilization. American Journal of Preventive Medicine, (45), 4, 441-447. 2. Megha, C. (2013, in print). A Statewide Medical Enhanced Prenatal Care

Program: Impact on Birth Outcomes. JAMA Pediatrics.]
Population strategies to improve birth outcomes continue such as the FASD program, smoking cessation, FIMR, MIHP, & NFP continue. Targeted strategies to reduce disparities remain a priority.

c. Plan for the Coming Year
The department of community health identified 8 strategic priorities to improve population health. The following are strategies that relate to the reduction of premature births.

A statewide perinatal coordinated system has long been supported by the MOD and can help to reduce preterm births. The perinatal care system is under development and will continue to be refined.

Build the infrastructure to support a high-quality system of home visiting programs and services. Expand local home visiting programs using evidence-based models, delivered to the highest-risk populations. Home visitation programs offer women and families social and medical supports throughout preconception, pregnancy and motherhood which can reduce preterm births.

The department will create a plan to address improving the health of women and girls using the recommendations from the MI Infant Mortality Reduction Plan and the MI Team of the National Governors Association Learning Network to assure health women entering into pregnancy. Preconception and interconception health care have been shown to reduce preterm births.

Additional journal articles regarding the effectiveness of MIHP in reducing preterm births and the evidence based home visitation's role in reducing infant mortality will be published in 2014.

State Performance Measure 4: *Percent of singleton births by mother's BMI at start of pregnancy greater than 29.0*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			25.5	25.5	22.5
Annual Indicator	24.6	25.5	25.7	22.5	26.2
Numerator	26614	26413	27038	24197	27210
Denominator	108019	103778	105021	107596	103879
Data Source	MI Vital Records	MI Vital Records	MI Vital Records	MI Vital Records	MI Vital Records
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	22	20	18	16	16

a. Last Year's Accomplishments

A Memorandum of Understanding to support inter-program referral, data sharing, and collaboration continues between the Michigan Department of Community Health WIC and MIHP programs. MIHP continues to provide standardized assessment and intervention around nutrition risks/needs and refers pregnant women and infants to WIC. WIC-eligible pregnant and breastfeeding women receive nutritional information during pregnancy and postpartum that promotes healthy prenatal and postpartum weight with emphasis on positive maternal benefits of breastfeeding. High risk pregnant clients are referred to a Registered Dietitian for nutrition counseling and continuity of care planning across programs. Interconceptual care, including gestational diabetes follow-up, is promoted in WIC clinics.

WIC has strengthened staff training on client behavior engagement. Web-based learning opportunities are accessible via Michigan Public Health Institute archived webinars (e.g., interconceptual health issues) and LMS training modules (e.g., WIC Participant-Centered Education Modules). 2014 Michigan WIC Conference, attended by 750 people, included the sessions "Positive Power of Influence" and "Progress & Next Steps in the War Against Childhood Obesity."

The impact on postpartum weight management is also supported by WIC's continued 20+ year partnership with Michigan State University Extension (MSUE) including Kellogg Foundation funding through September 30, 2014 to several Breastfeeding Initiative (BFI) Mother-to-Mother Peers. (See also Performance Measure #11).

The Maternal Infant Health Program (MIHP) participated in a CDC funded initiative in 2013 that focused on improving breastfeeding rates amongst low income women with a special focus on serving African American women. Through this project stronger alliances were forged with state WIC, the Black Mother's Breastfeeding Association and the staff of the Department's Chronic Disease program. WIC provided the 2 day "Breastfeeding Basics" training to a cohort of MIHP providers which improved the training and intervention capacity of the field of 140 providers.

MIHP requires that all eligible women and infants are referred to the WIC program which provides nutritional information during pregnancy and the postpartum period. Promotion of breastfeeding and related support, linked to healthy weight in women, is promoted in both WIC and MIHP. High risk pregnant and postpartum participants are engaged by a MIHP Registered Dietitian or referred back to the local WIC for nutrition counseling.

The MIHP Maternal Risk Identifier (MRI) was revised in 2013 to include more nutrition and breast feeding questions with accompanying standardized breastfeeding plans of care. Most of the new questions on the MRI mirror the MI-WIC assessment. In addition the MIHP "general education plan of care" (Plan of Care One) was adapted to include the four key points of the Governor's 4x4

plan (Maintain a Healthy Diet, Engage in Regular Exercise, Get an Annual Physical Examination, Avoid All Tobacco Use and Exposure) The entire plan is available at http://www.michigan.gov/documents/healthymichigan/Michigan_Health_Wellness_4x4_Plan_387870_7.pdf

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote healthy weight gain during pregnancy, and healthy weight management between pregnancies through MIHP and WIC.	X			
2. MIHP programs will assess pregnant women and infants nutrition and breastfeeding needs using evidence based risk identifiers (140 programs).	X			
3. Risk Identifiers will be entered into the State of Michigan Single Sign On (SSO) data base (approximately 55, 000 per year).			X	
4. Individual MIHP programs will provide nurtrition and breastfeeding durantion will be pulled when IT system that the capapbility.		X		
5. Individual MIHP programs will provide nutrition and breastfeeding services with fidelity to model (standardized Plans of Care).		X		
6. MIHP will promote the Governor's 4x4 plan.		X		
7.				
8.				
9.				
10.				

b. Current Activities

Mutual referral of eligible women continues between the MIHP and WIC programs. Board Certified Lactation Consultants serve as a back-up to local WIC agency's breastfeeding specialists, when situations require the technical assistance and expertise of someone outside the agency.

The WIC Division is offering an Intensive Lactation Management Course to approximately 50 local agency WIC staff in May 2014. Additionally, the WIC Division is providing two more Building Bridges to Breastfeeding Duration opportunities. Expectations are to maintain breastfeeding peer counseling services at their current level.

MIHP through its 140 agencies continues to provide standardized assessment and intervention around nutrition risks/needs and refers all pregnant women and infants to WIC. State staff are participating in the 2014 Healthy Places for Healthy People Conference which includes a panel discussing: minority mothers and babies; peer support for breastfeeding mothers; mom perspective; advocacy by community organizations; Local Health Department/Hospital partnerships; Toolkits for businesses and for working mothers and Michigan Infant Health Program (MIHP) support.

c. Plan for the Coming Year

The WIC Division intention is to advance 2014 activities and projects in 2015. We will continue to seek inter-department opportunities in collaboration and extension of resources for client benefit,

particularly to high risk clients. This will include WIC core services of nutrition education, breastfeeding promotion and support, and supplemental food packages to pregnant and postpartum women. High risk clients will continue to be referred to Registered Dietitians for nutrition counseling.

MIHP will continue to focus on the nutrition needs and risks of pregnant and infant Medicaid beneficiaries and will enhance its partnership with WIC to meet the needs identified.

The Maternal Infant Health Program (MIHP) is a well-established population-based home visiting program focused on serving all Medicaid-eligible pregnant women & infants up to age one in MI. The 140 MIHP programs in the state provide support to promote healthy pregnancies, positive birth outcomes, & healthy infants. Nutrition, healthy weight and breastfeeding will continue to be focal points of the interventions provided.

State Performance Measure 5: *Ratio between black and white children under 6 years of age with elevated blood lead levels*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			3.2	3	2.8
Annual Indicator	3.4	3.8	2.9	3.0	2.9
Numerator	896	816	576	468	382
Denominator	263	216	202	158	134
Data Source	MDCH Data Warehouse	MDCH Data Warehouse	MDCH Data Warehouse	MDCH Data Warehouse	MDCH Data Warehouse
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	2.6	2.4	2.2	2	1.8

a. Last Year's Accomplishments
The ratio between black and white children under six years of age with elevated (>= 10 ug/dL) blood lead levels decreased in 2013 to 2.85, just over the Annual Indicator of 2.8. Interestingly, if we were to define "elevated blood lead level" as any level >= 5 ug/dL (which is in line with the CDC's latest recommendations), then the ratio would be 1.3. On the other hand, if we used percentage of children with levels >= 10 instead of number of children, then the ratio between black and white children jumps to 4.5 in 2013 (or 2.2 using >= 5).

Among all races, the number and percentage of children with blood lead levels >= 10 ug/dL decreased again in 2013, from 790 (0.5%) to 653 (0.4%).

Progress was made implementing the Healthy Homes and Lead Poisoning Surveillance System (HHLPSS) database, but some issues remain before it can be fully implemented.

A new Education and Outreach Plan was developed, ready for implementation in the current year. Funding for education and outreach has been distributed using a formula that sends

greater funds to areas with higher incidence of lead poisoning (these areas have the higher percentages of black children experiencing lead poisoning).

CLPPP provided significant input to Michigan Medicaid's revision of the EPSDT chapter of the Medicaid Provider Manual, incorporating the CDC's recommendations lowering the reference level to 5 ug/dL.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase the % of children w/initial BLLs 5-19 receiving follow-up testing within recommended time frames.			X	
2. Increase the % of children with 5-19 whose follow-up testing indicates declining BLL.			X	
3. Increase the % of children with BLL >= 20 receiving nursing or EH services.			X	
4. Increase the # of primary care providers educated about lead.				X
5. Increase the # and % of children tested in accordance with the revised Statewide Testing Plan.			X	
6. Increase the # of presentations to RPO groups.				X
7. Increase the # of WIC staff, Great Start partners/parents and child care providers educated in E&O presentations.				X
8. Increase the # of cities with increased scores on Code Enforcement Scorecard.				X
9. Decrease the # and % of children w/elevated BLL, by county and statewide.			X	
10. Provide nursing TA to LHDs, Providers and parents.			X	

b. Current Activities

With the new Education and Outreach Plan as a basis, CLPPP is collaborating this year with local health departments for primary prevention activities in selected high-risk communities, and for statewide education of professionals who work with families. In addition, a new Provider Education Workgroup has begun work to determine best practices for reaching primary care providers statewide.

CLPPP is working with primary care providers, local health departments and families to assure appropriate follow-up and care for lead-poisoned children statewide. Contracts with three local health departments, covering the communities with the highest prevalence of lead poisoning, provide support for case management activities in those jurisdictions.

CLPPP maintains a database of all blood lead analysis results statewide, and enforces the mandate for labs to report all results to MDCH. The surveillance system is being upgraded in two ways: 1) a new Access database is being developed (replacing older software) to manage and process incoming lab files, to store data, and to export files to the MDCH Data Warehouse, where lead records are linked to Medicaid and MCIR; 2) the last remaining issues are being resolved with HHLPSS, which will replace STELLAR as the case manage system for local health departments, and will facilitate better collaboration between the State and locals. CLPPP will train/retrain local health department staff on the new system as soon as it is ready for full implementation.

c. Plan for the Coming Year

Continue to upgrade the surveillance system, working with MDCH partners to develop a standard HL7 message for blood lead, and working with laboratories to facilitate and standardize their reporting using HL7 via MIHIN and the MDCH Data Hub.

Develop capacity to link lead data with MCIR in order to access race/ethnicity data for the widest possible population.

Build on current locally-based primary prevention and education & outreach activities based on lessons learned in the current year.

Continue support for case management activities in the areas with highest prevalence of lead poisoning .

Revise the Statewide Testing Plan.

Provide a new annual report that includes tables, maps or graphs showing data on testing and elevated levels by geography and race/ethnicity. These reports will help identify areas around the state with the greatest disparity of lead poisoning between black and white children, which would in turn inform decisions on allocation of funding.

Roll out a new Toolkit for Education & Outreach, which will be available at CLPPP's website (www.michigan.gov/lead). The Toolkit will make use of existing resources and new content, to be used in print, on social media, and traditional media.

State Performance Measure 6: *Rate per 100,000 of Chlamydia cases among 15-19 year-olds*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			2800	2600	2300
Annual Indicator	2,780.7	2,745.0	2,626.6	2,344.0	2,010.4
Numerator	20387	20302	19426	17336	14869
Denominator	733158	739599	739599	739599	739599
Data Source	MI STD Database	MI STD Database	MI STD Database	MI STD Database	MI STD Database
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	2200	2100	2000	1900	1800

a. Last Year's Accomplishments
The Centers for Disease Control and Prevention, the National Preventive Health Task Force, and the National Center for Quality Assurance continue to support the science based recommendation for annual routine chlamydia (CT) screening for all sexually active females 24 and under. In 2013, the rate of reported chlamydia among all young adults age 15- 19 years was 2010.4 per 100,000 population. This rate has dropped steadily a total of 27% since 2010.

The Michigan Department of Community Health distributes pre-paid CT testing supplies to publically funded STD, Family Planning and Adolescent Health Clinics. The distribution of these resources is overseen by the Michigan Infertility Prevention Project Alliance (MIPP Alliance). Member of the Alliance include department staff from Adolescent Health, Family Planning, STDs,

and the Bureau of Laboratories. Additional representatives attend from screening sites across the state. The Alliance meets semi-annually.

In CY 2013 6,907 youth age 15-19 were screened in MDCH supported school-based and school-linked health centers (SB/SLHC). Among those screened in SB/SLHC, 11.6% tested positive for chlamydia and 1.7% for gonorrhea. In 2013, 2,673 of these tests were conducted via school-wide screening events conducted in Detroit area schools where 8% of all students were positive for chlamydia. As we repeat screening in schools a second or third year, positivity is dropping significantly which is great news.

In 2013 fifty-six SB/SLHC received support in the form of pre-paid tests for CT to screen those without other forms of payment. Of those found positive in these sites, 98% are treated in a timely manner, decreasing the rate of new infections.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Distribute CT screening resources to school-based/linked sites to increase access to screening.			X	
2. Monitor treatment completion and timeliness of those found positive.				X
3. Distribute partner notification tools to 100% of school-based clinics to increase the number of partners notified of their exposure.				X
4. Maintain 10% positivity in school based clinics through targeted applicaiton of publically funded screening resources.				X
5. Facilitate 90 day re-testing of patients who are found infected to identify reinfection in a timely manner. This will be accomplished through education, provision of pre-paid tests, and educational materials.			X	
6. Provide STD medications to sites to cover treatment of uninsured patients.	X			
7. Partner with health systems and public schools in high incidence communities to conduct school-wide screening events to increase access to CT screening.			X	
8.				
9.				
10.				

b. Current Activities

The CT screening project is an established program. Services remain rather stable from year to year with small adjustments. Current activities include:

• Distribution of pre-paid CT test requisitions
• Provision of medication for uninsured who test positive
• Education of providers on newest screening technology, and treatment guidelines
• Provision of partner notification tools to increase the number of partners informed of their exposure and treated
• Ongoing medical provider training on standards and guidelines associated with CT screening and treatment.
• Technical Assistance and provision of testing supplies to facilitate school-wide screening in high incident communities.

c. Plan for the Coming Year
Screening in SB/SLHC is supported by a combination of resources allocated through Adolescent Health Services and the STD Section. Centers for Disease Control and Prevention Guidelines call for annual chlamydia screening of females age 15-24. The Adolescent Health Program is increasing their enforcement of this guideline in MDCH supported sites. More routinized screening will increase diagnosis and treatment of this common asymptomatic infection.

The STD Section is working in partnership with the Michigan Department of Education to increase access to sexual health services. One component of this work is that we plan to etend school-wide screening to two new sites in 2014-2015.

State Performance Measure 7: *Percent of women physically abused during the 12 months prior to pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			5	4.9	3.2
Annual Indicator	3.1	5.0	3.3	4.4	4.4
Numerator	3538	5672	3601	4815	4815
Denominator	113090	113446	110004	109673	109673
Data Source	PRAMS	PRAMS	PRAMS 2010	PRAMS 2011	State Estimate
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	3.1	3	2.9	2.8	2.8

Notes - 2012
The total numbers of live births (denominators) vary slightly for each PRAMS indicator because some women refuse to answer certain questions. The total number of live births from PRAMS is also different from that from the Vital Records resident birth file because PRAMS does not include Michigan residents who delivered in other states, but the resident birth file does.

The performance measure is percent of women physically abused during the 12 months prior to DELIVERY, not pregnancy.

Notes - 2011
The total numbers of live births (denominators) vary slightly for each PRAMS indicator because some women refuse to answer certain questions. The total number of live births from PRAMS is also different from that from the Vital Records resident birth file because PRAMS does not include Michigan residents who delivered in other states, but the resident birth file does.

a. Last Year's Accomplishments
The Maternal Infant Health Program (MIHP) is a MI population-based HV program focused on serving Medicaid-eligible pregnant women & infants up to age one. The 140 MIHP programs in the state provide support to promote healthy pregnancies, positive birth outcomes, & healthy infants. Last year over 54,000 unduplicated beneficiaries were served in programs administered in Local Health Departments, Federally Qualified health centers, Migrant Health Centers, Indian Health Centers, hospital and OB clinics, community centers, private agencies and home health

care. There is at least one MIHP At least one in each county with 80 in SE M. Universal screening and education for domestic violence (DV) occurs at entry into the program when a woman is pregnant and again when the baby is born. Data from the screening tool is collected and is available for evaluation, as is information regarding whether she had a change in her relationship status. MIHP staff received training on domestic violence, using an adaptation of the Futures Without Violence curriculum. The training is taped and available on the MIHP website www.michigan.gov/mihp.

Once a MIHP participant is screened and the answers to her questions are entered into the state data base, a computer algorithm "scores" out her risk for DV. Standardized care coordination interventions are then utilized. MIHP staff realize domestic violence can reduce the effectiveness of home visitation services, that home visitors have a unique opportunity to observe clients' home life and relationship dynamics and that women who discuss issues around their violent households are 4 times more likely to use an intervention and 2.6 times more likely to exit the abusive relationship.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MIHP programs will assess pregnant and postpartum women on domestic violence concerns and needs using evidence based risk identifiers (140 programs).	X			
2. Risk Identifiers will be entered into the State of Michigan Single Sign On (SSO) data base (approximately 55,000 per year).			X	
3. Individual MIHP programs will provide domestic violence care coordination services with fidelity to model (standardized Plans of Care).		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Families in the Maternal Infant Health Program (MIHP) continue to receive domestic violence screening at intake and when the infant is born. Continuing Education Credits have been secured for Nurses and Social Workers in the Program for the "Family Violence and MIHP" training. Safety plans for women who screen positive are reviewed during the chart review portion of the 18 month certification review. In addition, an expectation has been put in place, which is also evaluated at the certification visit that a high risk for DV be addressed in the first 3 visits.

c. Plan for the Coming Year

Families in MIHP will continue to receive domestic violence screening at intake when pregnant and when the infant is born. The focus on reviewing safety plans for women who screen positive will continue as will the expectation that a high risk for DV be addressed in the first 3 visits.

State Performance Measure 8: *Percent of high school students who experienced dating violence*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			3.3	14	14
Annual Indicator		15.0	15.0	11.3	11.3
Numerator		78775	78775	472	472
Denominator		525168	525168	4194	4167
Data Source		YRBS/Health People 2020	YRBS/HEALTH PEOPLE 2020	MI YRBS Nat'l YRBS	MI YRBS Nat'l YRBS
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	10	10	10	9	9

Notes - 2012
*Note: In taking a closer look at the data provided in previous years, I discovered that there were inconsistencies in the data, specifically for the:

• Annual Performance Objective—the previous targets were very ambitious. More time is needed to reach this goal. The 2012 figure represents a more attainable goal.

• Numerator--the 2010 and 2011 numbers were incorrectly based on high school student count data. The 2012 number is based on the 2011 Michigan YRBS data, which is representative of Michigan's public high school youth. This explains why the 2010/2011 figures are drastically different from 2012.

• Denominator—Same as above.

Notes - 2011
YRBS is the same data as previous year because the new data has not been released yet.

a. Last Year's Accomplishments
The Adolescent and School Health Unit within the Division of Family and Community Health continued partnering with Regional School Health Coordinators (RSHC's), from local Intermediate School Districts and Educational Service Agencies, throughout Michigan to train teachers for implementation of the Michigan Model for Health(r) curriculum. This K-12 health education curriculum includes age-appropriate lessons and skills-building activities related to violence prevention, healthy and responsible relationships, as well as other topics that impact the health of today's youth.

In 2013, The Michigan Model for Health(r) was listed on the Office of Justice Program's (OJP) CrimeSolutions.gov site as a "Promising" program. The OJP, a U.S. Department of Justice program, houses multiple offices and bureaus, including the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Its CrimeSolutions.gov site aims to inform justice practitioners, communities and policy makers about effective and promising programs/practices in the areas of criminal justice, juvenile justice and crime victim services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Recruitment and training of Teachers in the implementation of the Michigan Model for Health ® curriculum.		X	X	
2. Evaluation of Michigan Model lessons.				X
3. Promotion of Medicaid Services for eligible families.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current activities include training teachers to implement the Michigan Model for Health(r) curriculum in grades K-12. With a focus on the major health concerns that impact today's youth, including violence prevention, healthy and responsible relationships, and drug use prevention, teachers implement the curriculum utilizing a variety of teaching tools, including skills building activities, technology, videos, reading materials, etc. In February 2014, two newly revised middle school modules were released--Social Emotional Health and Safety and Stay Drug Free Today for a Successful Tomorrow. The RSHC's were trained and are currently recruiting and training middle school teachers to implement these lessons.

Family and community involvement are also encouraged through the dissemination of Family Resource Sheets (FRS). FRS are sent home to the parents/guardians of youth who receive Michigan Model for Health(r) lessons in order to promote awareness and encourage dialogue between students and their families regarding lesson topics. In addition, families are educated about Medicaid eligibility requirements, services, and application processes in the event that they are in need of financial assistance, food assistance or health insurance.

The Michigan Model for Health(r) Evaluation Team will begin its evaluation of the recently revised high school lessons in the fall of 2014. The evaluation was postponed in 2013 due to recruitment challenges.

c. Plan for the Coming Year

The plan for FY 15 is to: continue promoting and training schools/teachers in the Michigan Model for Health(r) curriculum; expand the number of schools/teachers that implement the curriculum, including private and charter schools; and continue educating and equipping students with the necessary skills to make healthy choices and decisions. We will also continue to promote awareness of available Medicaid services for eligible families.

State Performance Measure 9: *Percent of children receiving standardized screening for developmental or behavioral problems*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013

Annual Performance Objective			18.2	18.2	27
Annual Indicator		18.2	18.2	25.3	25.3
Numerator		108524	108524	148299	145656
Denominator		596286	596286	586164	575714
Data Source		Nat'l Survey of Children's Health	State Estimate	2011/2012 Nat'l Children's Health Survey	2011/2012 National Survey of Children's Health
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	29	30	35	40	40

Notes - 2011
The Medical Services Administration of DCH received a grant to improve billing for developmental screening. As yet, the data is not reliable enough to report for this indicator. Training of the provider network is ongoing.

a. Last Year's Accomplishments
Through Project LAUNCH, began work with the Michigan Primary Care Association (an association of FQHCs) to create a developmental screening training tailored to the needs of FQHCs. Project LAUNCH is on track to meet its goal to increase developmental screening in the practices engaged in the project within the target community by 20% each year. MIECHV sites also met goals for developmental screening. The Primary Care Developmental Screening project (PCDS) trained a total of 79 physicians and 101 of their office staff to fully integrate screening into their daily practice.

A West MI NICU follow-up project began in March of 2011 based on MI Perinatal Guideline recommendations. NICU follow-up consists of a home visitation component & an enhanced developmental assessment clinic (DAC). Eligible infants are followed at 6 months, 12 months, 18 months & 24 months (adjusted) in the DAC. The project has a DAC in three communities on a monthly basis. Infants in the DAC see the neurobehavioral pediatrician, nurse, physical therapy, occupational therapy, speech & audiology, WIC & a psychologist. Infants are screened with the Bayley III. In 2013 the number of children seen in the DAC by county: 114 in Muskegon County; 71 in Ottawa County, and 189 in Kent County. Home visits by CSHCS program began in January 2013 to test the assessment forms. A statewide NICU follow-up committee convened in 2013. Three NICU follow up committees were formed: MIHP/CSHCS Linkage Workgroup, NICU Risk Assessment Workgroup & Developmental Assessment Program Workgroup.

All infants in the Maternal Infant Health Program (MIHP) receive developmental screening. At intake, babies are screened annually using Bright Futures questions. The Ages and Stages Questionnaire-3 (ASQ-3) and Ages and Stages Questionnaire: Social Emotional (ASQ:SE) are then used according to the periodicity schedule throughout the infant's enrollment in the program. Infants with scores that indicate more evaluation is necessary are referred to Early On.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue implementation of the Perinatal Guidelines, Levels of				X

Care recommendation for transition of NICU graduates through DAC & home visitation.				
2. Use lessons learned in West MI NICU follow up project to inform statewide NICU follow up program.				X
3. Continue to explore how developmental screening data might be linked through an early childhood data system.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Seven MIECHV local implementing agencies are participating in the HRSA HV CoIIN; two are focusing on developmental screening & referral with support from public health and Early On (MI Part C program). The Great Start early childhood administrative structure convenes the Great Start Operations Team (GSOT), a team of mid-level managers that provide oversight for collaborative grants/activities. This team is beginning a root cause analysis to understand the policies, funding, & other potential barriers that the state will need to address as it moves toward centralized data collection & information sharing related to developmental screening & results. This will be a critical step to take as the state prepares to establish a cross-agency early childhood data system, funded through Race to the Top Early Learning Challenge grant & a W.K. Kellogg Foundation grant.

The West MI project continues with multidisciplinary developmental assessment clinic visits in the three counties. CSHCS continues to make home visits. The state is moving toward statewide NICU follow-up planning & implementation. Lessons learned in the West MI project will help guide development of MI perinatal care system.

All infants in MIHP continue to receive developmental screening. Over 30,000 babies are screened annually at intake using Bright Futures questions, and ASQ-3 & ASQ:SE according to the periodicity schedule.

c. Plan for the Coming Year

The GSOT will conclude its analysis and make recommendations toward linking data about developmental screenings. This will link with data system activities under the state's new Race to the Top Early Learning Challenge grant, and its goals related to developmental screening. A cadre of Child Care Health Consultants will be established under the Race to the Top grant, which will enhance efforts to educate about developmental screening in the context of child care. Work with home visiting providers and programs will also continue to enhance quality screening and referral. All of these activities will also need to link with data collection and reporting related to Medicaid performance objectives.

Continue with statewide efforts for NICU follow-up. Plan to implement at least one pilot site for developmental assessment programing.

Infants in the Maternal Infant Health Program (MIHP) will continue to receive developmental screening using Bright Futures questions at intake and through use of the Ages and Stages Questionnaire-3 (ASQ-3) and Ages and Stages Questionnaire: Social Emotional (ASQ:SE)

according to the periodicity schedule throughout the infant's enrollment in the program. Infants with scores that indicate more evaluation is necessary will continue to be referred to Early On.

State Performance Measure 10: *Ratio of the percent of the minority population eligible for publicly-funded health programs to the percent of the white, non-Hispanic population eligible for publicly-funded health programs*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			79	80	1.8
Annual Indicator		2.3	2.0	2.0	2.1
Numerator		51.1	45.1	46.4	38.8
Denominator		22.5	22.7	22.7	18.6
Data Source		Medicaid Database	Medicaid Database	Medicaid Database	Medicaid Data, US Census
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.7	1.6	1.5	1.4	1.3

Notes - 2013
This measure was changed from last year based on comments from our 2014 Block Grant review to better represent a health equity objective. See also Detail Sheet for more explanation.

Notes - 2012
The definition of the performance indicator was changed in the 2014 application from a percentage served to a ratio of persons eligible. See Detail sheet for further explanation of the measure. We were not able to change the Annual Performance Objective for 2011 and 2012.

Notes - 2011
The definition of the performance indicator was changed in the 2014 application from a percentage served to a ratio of persons eligible. See Detail sheet for further explanation of the measure. We were not able to change the Annual Performance Objective for 2011 and 2012.

a. Last Year's Accomplishments
The PRIME (Practices to Reduce Infant Mortality through Equity) Steering Team and workgroups continued to work towards fulfilling the goals and objectives of the project. The project goals are to: 1) Develop and pilot a replicable workforce training and practice model for state MCH staff to reduce racial disparities in infant mortality in Michigan, with a focus on African Americans and Native Americans; 2) Use a state/local partnership network to codify effective efforts that undo racism and improve infant health; and 3) develop a sustainable quality improvement process. In addition, the Department's Infant Mortality Reduction Plan incorporated an objective to weave the social determinants of health in all strategies to reduce racial and ethnic disparities in infant mortality.

The Women, Infants and Children (WIC) Division participated in Health Equity Learning Labs. The Goals of the Health Equity Learning Labs are: 1) To foster institutional change to develop policies and procedures that always promote, and NEVER inhibit health equity; and 2)To incorporate equity thinking, perspectives and action into daily work assignments and

responsibilities.

A revised organizational assessment tool was administered to the CSHCS Division in January 2013. The organizational assessment gathered self-rated perceptions from CSHCS staff about organizational capacity and practices by asking questions which were grouped into six competency areas: 1) Cultural competence; 2) Perspectives of bureau programs and services designed to build capacity of local health departments to reduce racial health disparities; 3) Information sources used to gather information about racial health disparities; 4) Division's application of key concepts like institutional racism, social determinants of health and life course theory; 5) Knowledge and Skills (e.g. use of epidemiological data for program development); and 6) Division's community engagement. Additionally, the CSHCS Division participated in a 2.5 day Health Equity and Social Justice workshop.

Since 2011, the Native American Ad-hoc data group has met to develop a survey and process to administer Michigan's first Native American stand-alone Pregnancy Risk Assessment Monitoring System survey. The partnership is with MDCH, the Inter-Tribal Council of Michigan, Great Lakes Inter-Tribal Epidemiology Center, and Michigan State University. Michigan has conducted PRAMS since 1988 but typically only collect data for 5-6 Native American mothers each year. The stand-alone survey was conducted for all native births in 2012. MCH used a revised definition of "Native infant" to include infants whose fathers were Native American. The approach resulted in a 108 percent increase in sampling size. Additionally, a culturally sensitive approach was developed that resulted in a response rate over 50 percent. More than 1,300 surveys were completed.

To date, the PRAMS Epidemiologist has assessed the raw, unweighted 2012 data for signs of response bias, according to where "American Indian/Alaskan Native" appears in the birth certificate and infant age at survey. No significant results suggest bias from these variables, and the next steps for response analysis are to test other potentially relevant birth certificate variables and formally publish the results in a methodological report.

The PRIME website (http://prime.mihealth.org/) was launched in January 2013. The website includes relevant data on infant mortality and definitions and videos that describe health equity, social determinants of health and racism.

The PRIME Local Learning Collaborative (LLC) continued to share their opportunities and challenges in addressing racism and equity within their local agencies. In August 2013, the group supported merging the LLC and the PEDIM Action Learning Collaborative.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Completed organizational assessment for the CSHCS Division				X
2. Conducted PRAMS survey of mothers of Native American infants				X
3. Trained CSHCS Division staff on Health Equity and Social Justice curriculum				X
4. Launched PRIME website				X
5. Conducted Health Equity Learning Labs with WIC Division				X
6. Merged PEDIM with the Local Learning Collaborative activities				X
7.				
8.				
9.				
10.				

b. Current Activities
The PRIME project has been funded primarily by a grant from the WK Kellogg Foundation. This is the last year of the grant. Through this funding, PRIME implemented three different equity training curricula for BFMCH staff. Resulting from the trainings and development of equity plans is the PRIME toolkit/curriculum guide that provides an overview of the PRIME practice model. Staff of the CSHCS Division have completed their organizational assessment and participation in the HESJ Workshop. During FY 2014, the Division is participating in the Health Equity Learning Labs.

The partnership between the MDCH, Inter-Tribal Council of Michigan, Great Lakes Inter-Tribal Epidemiology Center, and the Michigan State University Office of Survey Research continues to work on the Native American PRAMS. Currently, 2012 data is being analyzed and mothers who gave birth to a Native infant in the last 9 months of 2013 are being surveyed. Starting with April 2013 births, NA PRAMS began offering moms the option to complete surveys online. The goal of the online option is twofold: 1) to increase responses through a more convenient way to participate and 2) to lower operational costs of mail and telephone survey modes.

In early February 2014, the newly formed Perinatal Infant Oral Health (PIOH) Advisory Committee met to further develop the draft Action Plan that was outlined by the PIOH conference (August 2013) participants, including the social determinants of health.

c. Plan for the Coming Year
Funding requested in the new proposal to Kellogg Foundation will be used to develop a plan to implement the PRIME practice model throughout MDCH (one of 18 departments of state government) and its external partners. Implementation of the practice model in other divisions will allow for further refinement of the model and continuous quality improvement processes. Senior leadership will engage in health equity and Culturally and Linguistically Appropriate Services (CLAS) training. Development of the implementation plan will include meeting with each of the target divisions, providing an overview of the model and developing a timeline for implementation. PRIME will begin implementation of the model in at least one division within this grant period. MDCH will also share the model with local partners and Region V's Collaborative Improvement Innovation Network.

Principles of health equity and social determinants of health will continue to be incorporated into strategies for reducing racial and ethnic disparities in infant mortality.

UM-Office of Public Health Practice (OPHP) arranged for the 1st pilot of the Learning Labs with WIC to be videotaped and transcribed. UM-OPHP is interested in collaborating with PRIME to develop online components for the Learning Labs. The project will determine the feasibility of developing online components after completion of the 2nd pilot of the Learning Labs with CSHCS. In 2014, UM-OPHP is interested in supporting the development of the PRIME toolkit.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	8.4	8.4	8.4	8.5	8.3
Numerator	9771	9685	9576	9535	9284

Denominator	116610	114717	114159	112708	112503
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Michigan percentages of LBW infants remain higher than national averages. Michigan's LBW rate stagnated between 2005 and 2001. Low birth weight percentages have persisted in the eight percent range for the previous decade. Disparities persist. The percent of low birth weight births in 2012 to whites was 7.0%, which was lower than blacks (14%), American Indian (8.6%) and Asian & Pacific Islander (9.8%). The percent of inadequate prenatal care by Kotelchuck Index was highest for black women with LBW infants (13.7%) as compared to white (8.8%), American Indian (8.3%), Asian Pacific Islander (8.3%), Arab ancestry (7.7%) and Hispanic ancestry (7.0%).

Low birth weight has been linked to multiple births. The rate of twin births has remained fairly stable over the previous decade with 16.7 twin births per 1000 live births in 2002 to 17.5 twin births per 1000 live births in 2012. Triplet births have declined in the same time period with 62.5 triplet births per 100,000 live births in 2002 and 46.1 triplet births per 100,000 live births in 2012.

Michigan's low-birth weight rate is higher than that in 30 other states. Low birth weight is the second most common cause of infant mortality and has been linked to several causes including maternal diseases, infections, smoking, multiple births, nutritional deficiency and stress. Social determinants of health play a role in low birth with infants.

Michigan is working on the development of a perinatal care system to improve birth outcomes in the state. Additionally, high quality home visitation programs and services are in place to provide support service to Medicaid women so that they have healthy pregnancies, good birth outcomes and healthy infants.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	6.5	6.6	6.5	6.6	6.4
Numerator	7311	7301	7162	7197	6953
Denominator	112315	110440	110032	108593	108334
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

Michigan still has much work to do to give infants a healthy start. Trends in live births weighing less than 2500 and 1500 grams have remained relatively unchanged over the previous decade and were summarized in the 2013 application. A critical trend is the persistence of racial disparity in low and very low birth weight infants. The percent of black very low birth weight infants is nearly 3 times greater than whites (3.3% versus 1.2 %) and nearly double for infants weighing 1,500 -- 2,499 gms (10.8% vs. 5.7%). LBW, along with prematurity has remained the leading cause of infant death in Michigan.

From 2005 -- 2011 there was a large increase in births to unmarried women, rising from 36% of all births to 42%, and 18 percent jump. Children born to single mothers are more likely to face economic hardships and insecurity.

Policies that grow opportunities for low-income families are needed to help reduced the trend in low birth weight and very low birth weight infants, such as:
•Prioritize and invest in prevention strategies such as health education, pregnancy prevention, access to prenatal care, home visiting and parent education resources
•Accept federal funds to expand the eligibility of Medicaid under the Affordable Care Act, which will increase access to health services for the most economically disadvantaged women in Michigan.
•Decrease the pay equity gap in Michigan to help female-headed households. The increase in births to single women makes the issue more imperative to the well-being of children.
•Increase job training opportunities for high school graduates to build skills necessary to earn family-sustaining wages.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.7	1.7	1.6	1.6	1.6
Numerator	1931	1897	1827	1775	1832
Denominator	116610	114717	114159	112708	112503
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The Bureau routinely monitors data for very low birth weight (VLBW) infants from the state's Vital Records. The rate of VLBW infants has remained relatively the same for the last five years despite existing program efforts. In 2012, 1.6% of all births were VLBW. The percent is the same for 2013. This is higher than the national rate of 1.4%. The percent of black VLBW infants (3.2%) is nearly triple that of white VLBW infants (1.2%). Between 2001 and 2011 the percentage of multiple births in Michigan was unchanged. Major risk factors for very low birth weight infants include multi-fetal pregnancy, prematurity, smoking, inadequate maternal nutrition and extremes of maternal age. Infants born with VLBW are at increased risk of dying in their first year of life.

The rate of twin births in Michigan have remained about the same for the past five years. In 2012 the rate was 17.5 per 1,000 births, which is lower than the national rate of 33.1 per 1,000 births for 2012. The number of infants born in twin deliveries was 1,972 in 2012, the lowest number

since 1998, but still higher than the lowest number of twins delivered in the previous three decades (1982 there were 1,377 twin births).

The department is using Perinatal Periods of Risk to analyze excess risk of infant mortality. PPOR suggests that 68% of excess mortality could be averted if Michigan were to address the health of women before they become pregnant and during pregnancy. Strategies to reduce VLBW infants include alcohol prevention strategies through the Fetal Alcohol Syndrome Disorder program, Smoking Cessation program which supports a tobacco Quitline to help women reduce or stop smoking during pregnancy and home visitation programs to support women during pregnancy and complement provider prenatal care visits such as through the Nurse Family Partnership programs (NFP) and through the Maternal Infant Health Program (MIHP). In addition, strategies to improve preconception health, to reduce adolescent pregnancies, as well as family planning strategies to promote pregnancies that are planned and wanted continue to be priorities. The state is working on the planning and beginning implementation of a statewide perinatal care system. Equity in black/white birth outcomes is a state priority.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.3	1.3	1.2	1.2	1.2
Numerator	1408	1422	1302	1295	1311
Denominator	112315	110440	110132	108593	108334
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The Bureau routinely monitors data for very low birth weight (VLBW) infants from the state's Vital Records. The rate of VLBW infants has remained relatively the same for the last five years despite existing program efforts. The rate of VLBW singleton births has also remained relatively the same for the last five years. The disparity of white/black VLBW infants persists. White infants born VLBW was 0.9% compared to 2.7% for VLBW black infants.
Trends in birth outcomes for singleton births are examined because multiples births have, on average, shorter gestations and lower birth weights than singleton births. The lower the infant's weight at birth, the greater the risk of poor pregnancy outcome. Nationally in 2010, 22% of infants born at less than 1,500 grams did not survive their first year, compared with just over 1% of moderately LBW infants, and 0.2% of infants born at 2,500 grams or greater.
See additional discussion in HIS #02A.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**

Annual Indicator	54.9	46.2	44.1	37.1	32.6
Numerator	19834	16189	15451	12892	11734
Denominator	361443	350292	350202	347674	360122
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The Michigan Disease Surveillance System (MDSS) is the statewide reporting internet-accessible disease reporting system used by laboratories, clinics, and local and state health department staff to monitor all communicable diseases. Over 40,000 positive chlamydia results are reported via this system each year, including 45,091 chlamydia cases in 2013.

In 2013, the rate of reported chlamydia among females age 15- 19 years was 32.6 per 1,000 population. This rate has dropped steadily in recent years.

Because of a lack of population-wide screening data for comparison, we are unable to conclude how much of this decline may result from reduced testing. However because of the sharp drop among the 15- 19 year-old population, at least a portion of the drop is due to a true reduction in disease. Furthermore population based surveillance studies including NHANES show corresponding decreases in national studies.

Overall rates of infection have decreased overtime, due in large part to increased screening in the private sector where age based recommendations call for annual chlamydia screening for females age 15-24. At the same time rates remain 8-9 times higher among African Americans compared to their white counterparts. MDCH is committed to closing this gap. MDCH supports chlamydia screening in STD and family planning clinics, as well as school-based clinics, and juvenile detention centers.
The majority of screening that is supported by Federal and State dollars is targeted to large urban areas where the populations are disproportionately African American, and where access to health care service is limited by factors including income, insurance coverage, and transportation.

Given the high rate of infection among 15-19 year olds, in 2013-14 MDCH continued screening in select high-schools. The assignment of staff hours, and chlamydia screening resources to this initiative was a thoughtful response to the disproportionate levels of CT among African American youth age 15-19 in Detroit. They have the highest rates of infection of any population in the state. MDCH, in partnership with St. John Health Systems, who manage a number of school-based health centers, has facilitated ten screening events in four years; adding one new school each year. Consistently, positivity in each school has started at 10% or over, and dropped year after year. The effect of screening and treating a cohort of youth can be seen in the data from our first school, which we have now returned to four times.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**

Annual Indicator	11.6	12.6	12.8	13.0	12.4
Numerator	18557	19983	20298	20239	19677
Denominator	1604392	1586442	1586442	1557109	1588472
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The Michigan Disease Surveillance System (MDSS) is the statewide reporting internet-accessible disease reporting system used by laboratories, clinics, and local and state health department staff to monitor all communicable diseases. Over 40,000 positive chlamydia results are reported via this system each year, including 45,091 chlamydia cases in 2013.

In 2013, the rate of reported chlamydia among females age 20- 44 years was 12.4 per 1,000 population. This rate has remained relatively stable since 2010 with slight fluctuations due to population.

Because of a lack of population-wide screening data for comparison, we are unable to conclude how much of this decline may result from reduced testing. Population based surveillance studies including NHANES show corresponding decreases in national studies.

Overall rates of infection have decreased overtime, due in large part to increased screening in the private sector where age based recommendations call for annual chlamydia screening for females age 15-24. At the same time rates remain 8-9 times higher among African Americans compared to their white counterparts. MDCH is committed to closing this gap. MDCH supports chlamydia screening in STD and family planning clinics, as well as school-based clinics, and juvenile detention centers.
The majority of screening that is supported by Federal and State dollars is targeted to large urban areas where the populations are disproportionately African American, and where access to health care service is limited by factors including income, insurance coverage, and transportation.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	110762	79930	19958	928	3305	61	6580	0
Children 1 through 4	464952	337389	81583	3850	14364	212	27554	0
Children 5 through 9	619561	461955	100768	5181	19606	292	31759	0
Children 10 through 14	659268	497873	108343	5563	18808	301	28380	0
Children 15 through 19	697010	527181	120796	6050	18272	288	24423	0

Children 20 through 24	713992	537537	127846	5714	23268	351	19276	0
Children 0 through 24	3265545	2441865	559294	27286	97623	1505	137972	0

Notes - 2015

Narrative:
The state's total population increased slightly from 2011 to 2012 (.07%). The population under age 18 has declined every year since 2000, while the portion of the population over 65 has steadily increased during the same time period. Live births have decreased every year since 2006. The state's racial/ethnic composition has changed slightly since 2000. Whites continue to make up the largest proportion of the population (81.2%). The largest increase in the non-white population has been among Asians, increasing from 1.2% of the total population in 2000 to 2.9% in 2012.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	102268	8494	0
Children 1 through 4	424103	40849	0
Children 5 through 9	567813	51748	0
Children 10 through 14	612150	47118	0
Children 15 through 19	653393	43617	0
Children 20 through 24	674405	39587	0
Children 0 through 24	3034132	231413	0

Notes - 2015

Narrative:
The Hispanic population has more than doubled since 2000 from 2.2% of the total population to 4.6% in 2012. During that same time period, the proportion of children in Michigan under age 18 of Hispanic origin has increased from 3.1% to 7.7%.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	**Total**
Total Population	9883360
Percent Below: 50% of poverty	7.5
100% of poverty	16.3
200% of poverty	36.4

Notes - 2015

Narrative:
The percent of Michigan residents in poverty increased from 10.9% in 2007 to 17.5% in 2011, then decreased to 17.4% in 2012.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	2551553
Percent Below: 50% of poverty	10.7
100% of poverty	22.8
200% of poverty	46

Notes - 2015

Narrative:
The percent of children under age 18 in poverty continued to increase from 2007 to 2012 (15.9% in 2007, 24.9% in 2012).

F. Other Program Activities

The Count Your Smiles (CYS) survey was designed to address dental outcomes in Michigan that pertain to those HP2010 objectives. In addition, CYS will contribute to Michigan's oral health surveillance system. The purpose of the program is to spotlight oral disease prevalence in third grade children and address oral health disparities among children for both dental disease and access to dental care. The report also determines the use of sealants and community water fluoridation. The survey followed the format of the Basic Screening Survey, a national survey developed by the Association of State and Territorial Dental Directors. The Count Your Smiles was conducted in fall 2005 to determine sealant placement rates and oral disease prevalence in third grade children in Michigan. A statistical sampling included 76 elementary schools and approximately 1586 children participated in the program.
/2012/ The Count Your Smiles (CYS) survey was completed in 2010 and the data collected and reviewed the oral health epidemiologist. A final report regarding the results was drafted. Plans are to finalize and publish the CYS survey report, and disseminate it to external and internal stakeholders for further advocacy work to expand the school-based sealant program. //2012//

The Michigan Department of Community Health Oral health program and Department of Environmental Quality (Water) collaborate to promote community water fluoridation. This collaboration has proven success as demonstrated by the reestablishment of community water fluoridation in additional 3 communities within the state. MDCH utilized the data from the Count Your Smiles of 3rd grade children in Michigan to gain administrative support to develop a state-wide dental sealant program for 2nd grade high risk children.

The second Count Your Smiles 2009-2010 started in September 2009. The survey was planned to wrap up by 30th April 2010 but, due to increased recognition of the program, the time line is extended as more schools are interested in taking part in the survey. The purpose of the survey is similar to the previous survey conducted in 2005-2006, but now also focuses on issues such as the effect of dental insurance in obtaining dental treatment, and ethnicity-related oral disease prevalence and the occurrence rate. The statistical sample this time includes 78 schools with 1,989 children to date, expecting a few more schools to participate in the program.

/2013/ The Count Your Smiles Survey was published in 2011 and demonstrated the need for continued advocacy on the implementation of dental prevention programs. The oral health findings were published in the Kids Count in Michigan Databook 2011 published by the Michigan League of Human Services. The information also provides support for earlier interventions from infancy through age five in developing an infant oral health program for medical providers and other early childhood organizations. //2013//
/2014/ The Oral Health Program published the Burden of Disease document in January, 2013. This document provides information related to dental caries and periodontal disease. In addtion, it provides information on disparities, systemic health and societal impacts. The Burden of Disease document is updated every three years to view trends and impacts of services on oral diseases. The document provides information on practices of community water fluoridation and school-based dental sealant programs. //2014// The Oral Health Program contracted with the UM Child Health Education and Research (CHEAR) Unit to publish an updated Healthy Kids Dental utilization report. ***/2015/ Oral Health held a Perinatal Oral Health (POH) conference in Aug., 2013. The conference summary & POH workplan was published with 5 objectives. A POH Steering Committee was established. Action plans on the 5 objectives will be developed. Healthy Kids Dental utilization report was updated.//2015//***

1-800-26-BIRTH is staffed by health or social service professionals to answer both information as well as calls of pregnant women and parents. The staff are updated, quarterly, on the availability of services, eligibility requirements, and contact persons for local prenatal care and WIC providers and assist the client in identifying these and other providers in the client's community. Counselors are trained to respond to a broad range of health care needs. The hotline is marketed by local and state agencies through pamphlets, posters and public service announcements. Several times a year a flyer describing this service is mailed with every Medicaid identification card to each recipient and in AFDC warrants. In FY 2009, 6,771 calls were handled by the hotline, not including 194 wrong number calls and 861 undetermined calls.
/2012/ In 2009 the hotline served 9,215 clients. //2012//
/2012/ In FY 2010, 11,653 calls were handled by the hotline. Included in the total were 213 wrong number calls and 1,041 calls that were undetermined. //2012//
/2012/ Effective October 1, 2011, the MCH hotline will be managed by Michigan 2-1-1, a United Way of Michigan operation. The statewide service is operated via eight regional locations that specialize in providing health and human services information via the phone or web, using a regularly updated data base specific for the coverage area. The regional offices operate with trained call specialists and under the umbrella of the state 211 coordinating office. //2012//
/2013/ For FY 2010-2011 there were 10,408 women and infants served by the program. Michigan has used the MI Healthy Babies to promote the 2-1-1 as a community services resource for prenatal women and parents. We are making a transition to 2-1-1 in entirity and a mobile smart phone site has been developed to promote either telephone or web access for community services information and assistance. We envision at some future date the 1-800-26Birth number may be phased out. 1-800-26Birth has not been phased out for WIC. WIC is using the number in current promotion. //2013//
/2014/ The 1-800-26Birth number has been transferred to a statewide 211 resource hotline as of October 1, 2012. 1-800-26Birth is used by WIC only. WIC averages 1,000 calls per month. //2014// 2015/. 800 Birth number received 17,379 WIC calls in 2013. The 211 resource hotline serves all MI counties except one in 2013.//***2015//***

Promising Practices for Reducing Racial Disparities in Infant Mortality in Michigan (WKKF Grant) -- The Department has received a grant from the Kellogg Foundation to develop a model curriculum and tool-kit that MDCH and local/state health departments may use to address disparities in health outcomes. The tool-kit will include strategies and tools to promote continuous quality improvement, collaboration and accountability, and public sharing of measurable outcomes that reflect racial and health equity. The project goals are to identify and eliminate institutionalized discriminatory policies and practices in MDCH MCH and to focus more of MCH funding, policy and practice on monitoring and addressing social determinants of racial disparities in infant mortality.

/2013/ The project is now called PRIME (Practices to Reduce Infant Mortality through Equity). In December, 2010, the Kellogg Foundation granted an additional 3 years of funding for the project. A steering team has been established to provide leadership and guidance to the overall goals, objectives, and evaluation of the project. A Project Coordinator was hired in September 2010. Between March-May 2011, 170 staff from MCH and the Division of Health Wellness and Disease Control, along with members of PRIME, attended a two-day Undoing Racism Workshop facilitated by the People's Institute for Survival and Beyond. In addition, state staff received training in the Health Equity and Social Justice curriculum developed by Ingham County Health Department in the Fall of 2011. //2013//
/2014/ BFMCH staff attended Health Equity & Social Justice workshops. Over a 5 month period, WIC staff piloted Health Equity Learning Labs which are designed to incorporate equity thinking & action into staff's daily work. Lab revisions will be made to promote sustainability & replication. CSHCS staff will participate in the Labs in the fall. PRIME distributed MI's 1st stand-alone PRAMS survey for mothers of Native infants. The PRIME Website launched in January. //2014//
2015/Data from the PRAMS 2012 Native American births are being analyzed & a survey of 2013 births is being conducted. The PRIME practice model continues to be refined with adjustments to Health Equity Learning Labs as conducted with staff of the CSHCS Division. A new grant application has been submitted to the WK Kellogg Foundation for model implementation in other Department areas.
Feasibility of an online training program for all staff is being explored. A Health Equity Status Report was released in November 2013. The PRIME practice model will be shared in a toolkit/curriculum guide by October 2014. //2015//

/2012/ MDCH was awarded a grant "MI Healthy Baby" for the period of Sept. 1, 2010 -- Aug. 31, 2013. The goal of this project is to raise the awareness of women, men, and expectant parents about the need for preconception, prenatal and interconception care; and provision of resources for information on parenting and family support utilizing traditional and electronic media. The grant will help MDCH address high rates of preterm birth, low birth weight and racial disparities which contribute to infant deaths by using traditional and electronic media to engage and link the intended population to community resource.***/2015/ for before,during & after pregnancy.//2015//***

G. Technical Assistance

PRIME will assess and develop strategies to address the ongoing technical assistance and quality improvement needs for MCH staff that received the initial equity training provided in PRIME. The TA includes consultation for staff related to addressing obstacles to implementing their equity plans. This work will a)provide technical assistance to staff in implementing 2 year equity plans; b)convene a group of experts to assist with developing protocols for incorporating equity into administrative functions (contracting; resource allocation; policies); and c)share equity work and results developed with MDCH staff, local and Region V partners (Brown bags, webinars, webcasts, conferences, meetings). Outcomes of the TA and consultation needs identification will be assessed using a survey of BFMCH staff during the last quarter of the project period. The survey will include questions that assess division practice and policy changes.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	18019600	18135162	18086500		18682500	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	45270000	31849430	55721400		41309700	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	996800	522662	1005900		1009300	
6. Program Income *(Line6, Form 2)*	63943100	66234700	66799700		67522400	
7. Subtotal	128229500	116741954	141613500		128523900	
8. Other Federal Funds *(Line10, Form 2)*	378618492	288917900	283877140		316990885	
9. Total *(Line11, Form 2)*	506847992	405659854	425490640		445514785	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	0	0	3450000		2708000	
b. Infants < 1 year old	63943100	69604853	67349700		70572400	

c. Children 1 to 22 years old	8453700	4960818	8784400		9258500	
d. Children with Special Healthcare Needs	53155800	38726177	58770800		42565500	
e. Others	2509900	3130434	2945900		2927700	
f. Administration	167000	319672	312700		491800	
g. SUBTOTAL	128229500	116741954	141613500		128523900	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		66392		91045	
c. CISS	150000		0		140000	
d. Abstinence Education	3377694		3357851		4599076	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	198448737		198519663		197836133	
h. AIDS	1212495		1212495		1149797	
i. CDC	897730		820542		865542	
j. Education	0		0		0	
k. Home Visiting	5814126		6672500		5557057	
k. Other						
HRSA	270000		270000		682635	
Title X	7627610		7827610		7275000	
Title XIX	160303500		64911900		98794600	
Preventive Block	416600		218187			

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		**FY 2014**		**FY 2015**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	62522100	48971299	72529400		58595200	
II. Enabling Services	58644500	60679646	61448400		61391200	
III. Population-Based Services	6895900	6771337	7323000		8045700	
IV. Infrastructure Building Services	167000	319672	312700		491800	
V. Federal-State Title V Block Grant Partnership Total	128229500	116741954	141613500		128523900	

A. Expenditures

Expenditures for FY 2009 reflect changes in federal and state appropriation amounts. On Form 3, Line 5, the difference between the budgeted amount for FY2009 and the expenditures is due to decreased donations to the Children's Special Health Care Fund. The decreased amount in federal funding (Form 3, line 1) is the actual final Title V allocation.

On Form 4, the difference between 2009 budget and expenditures for "Others" represents the cut in state funds to family planning and pregnancy prevention programs. The difference in Line I.f. between budget and expenditures is the elimination of invoice processing charges for CSHCS (also shown on Form 5, Line IV).

In a unique situation, expenditures in the CSHCS program were significantly higher than the budgeted figure due to one complicated hemophilia case (Form 3, line 3; Form 4, line I.d; Form 5, line I).

/2012/On Form 3, Line 2, the difference between budgeted and expended is due to funding shifts between federal and state sources as a result of the change in the federal match rate under ARRA. This effect is also evident on Form 4, Line I.d. On Form 3, Line 5, the difference between the budgeted amount for FY2009 and the expenditures is due to decreased donations to the Children's Special Health Care Fund. The decreased amount in federal funding (Form 3, line 1) is the actual final Title V allocation.

On Form 4, the difference between budgeted and expended funds on Line I.e "Others" reflects the cuts in state funds for Family Planning and Pregnancy prevention programs. The difference between budgeted and expended funds for Infrastructure Building on Form 5 is due to the elimination of invoice processing charges for the CSHCN program.//2012//

/2013/The difference between budgeted and expenditure figures for 2011 reflect the shift of funding sources from ARRA federal funds to state funding (Form 3, line 3; Form 4, line I.d; and Form 5, line I); and the re-negotiation of the WIC formula rebate agreement (Form 3, line 6; Form 4, line I.b, and Form 5, line II).//2013//

/2014/Expenditures were close to the budgeted levels except for Children's Special Health Care Services and Pregnancy Prevention ("Others" and "Direct Care Health Services"). Expenditure levels for CSHCS can vary considerably from year to year, depending on the claims submitted for reimbursement. The reduction in Pregnancy Prevention expenditures reflect the continued reduction in state investment in those programs.//2014//

/2015/Overall expenditures for the FY 2013 MCH Block Grant Partnership were approximately 9% below budgeted level. The difference is primarily in state funds for CSHCS. The budget overestimated funding required for CSHCS services. This difference is reflected on Forms 3 (Line 3), 4 (Line I.d) and 5 (Line I).

On Form 4, the budget and expenditures for FY 2013 reflect a reclassification of expenditures between two population groups based on a detailed review of actual expenditures. Approximately $3.4 million was shifted from Children 1-22 (Line I.c) to Infants (Line I.b). This funding shift is carried through to the FY 2015 budget. The 2013 expenditures for the Infant category also include additional state and federal investment in home visiting programs and programs to reduce infant mortality. On Line I.e, "All Others," expansion of pregnancy prevention/family planning services was supported by other federal and state sources. Under Administration (Line I.f), expenditures include funding for one position in the Childhood Lead Poisoning Prevention Program. Expenditures for this position are also included on Form 5, Line IV. Infrastructure Services.//2015//

B. Budget

The maintenance of effort level from 1989 is $13,507,900. This amount represented state funding for Children with Special Health Care Needs, Family Planning, Adolescent Health, Local MCH and WIC. Current MOE level is maintained by expenditures for CSHCS.

The projected match for FY 2011 is $34,492,500. In addition to state general funds, the federal-state partnership includes program income from the WIC and newborn screening programs and Children's Trust Fund monies supporting CSHCN.

Other funding sources that support MCH programs include Title X (Family Planning), WIC, Medicaid and grants from other federal and foundation sources.

The change in budgeted funds from 2010 to 2011 reflects an increase in Program Income for Newborn Screening fees and WIC Rebate (Form 3, line 6; Form 4, line I.b; Form 5, lines I and III), cuts in state funding for Family Planning and Pregnancy Prevention (Form 3, line 3; Form 4, line I.e; Form 5, line I), and elimination of invoice processing charges for CSHCS (Form 3, line 3; Form 4, line I.f; Form 5, line IV).

/2012/Budgeted figures for the federal Title V allocation on Form 3 for FY 2012 reflect the authorized spending level, as opposed to the final grant award. There were no other significant differences between FY 2011 and FY 2012 budgeted figures.The other line items are based on best estimates of the state and federal resources that will be appropriated to us.//2012//

/2013/ Budgeted figures for 2013 reflect funding levels authorized by the State at this point. Funding levels were generally steady from 2012 to 2013 except for pregnancy prevention programs. State funding cuts for this program can be seen on Form 4, line I.e ("Others").//2013//

/2014/The budget for 2014 includes Title V funding for one staff position in the Childhood Lead Poisoning Prevention program and additional state funding for infant mortality reduction activities, including development of a regional perinatal system, revised Safe Sleep campaign, home visiting services for first-time mothers, and improvement of the pre- and inter-conception health status of women. Under "Other Federal Funds," the reduction in Title XIX funds reflects the implementation of managed care for CSHCN in FY 2014 and the shift of related funding from the Title V Director to the Medicaid program.//2014//

/2015/The budget for 2015 reflects adjustments in appropriations/awards based on FY 2013 expenditures and additional federal and state investments in home visiting and infant mortality reduction programs. The budgeted amount for Federal Allocation (Form 3) is based on the spending authorization approved by the State Legislature. Line 6 includes increased fees for newborn screening.

On Form 4, the following adjustments are made between FY 2014 and FY 2015 budgets:

- ***One-time funding in 2014 for infant mortality activities was deducted from the 2015 budget for Pregnant Women.***
- ***Additional funding is included in Line I.c and Form 5 (Line I) for approximately 1.5 FTE's in lead poisoning prevention program for work related to monitoring local MCH contracts, a .2 FTE epidemiologist position and other activities covered under the Block Grant.***
- ***CSHCS budgeted figure for 2015 is based on lower than predicted expenditures in 2013 and 2014 (also reflected in the difference between 2015 and earlier budgets for Direct Care Services on Form 5).***

On Form 5, the Population Based Services line includes additional newborn screening fees in 2015. In Infrastructure Services, an epidemiologist position, at .2 FTE, has been added for the Lead Poisoning Prevention program. This position will direct and assist the Data Manager in creating annual and quarterly reports that will best inform stakeholders

and the general public statewide. The epidemiologist will also make recommendations for improving the surveillance system in its current form, and into the future.//2015//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.